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This book is addressed to police administrators, hospital administrators, prosecutors, and citizens involved in community action who are prepared to re-examine their agencies' response to cases of rape. It provides information and analysis to spark such a review and outlines suggestions for coping with problems that commonly hinder change. The discussion is confined to forcible rape of adult women, generally defined as the carnal knowledge of a female through the use of force or threat of force by a male other than her husband. The book is divided into four sections: "The Police Response," "The Response of Medical Facilities," "The Response of Prosecutors' Offices," and the "Response of Citizens' Action Groups." The material presented in each is based upon the findings of national surveys conducted among each of these four groups, with special emphasis placed on agencies that have begun innovative changes in their approach to cases of rape. Each section presents findings from these nationwide surveys and then suggests guidelines for other seeking ways to improve their procedures in such cases. Insights gained from monitoring rape victim projects or innovations underway in six jurisdictions are presented in Appendix V. A basic finding in these studies was that the function of police departments, hospitals, prosecutors, courts, and citizen groups are highly interdependent. (Author)

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RAPE AND ITS VICTIMS:

A REPORT FOR CITIZENS,
HEALTH FACILITIES,
AND CRIMINAL JUSTICE AGENCIES

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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NATIONAL INSTITUTE OF LAW ENFORCEMENT AND CRIMINAL JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION
U.S. DEPARTMENT OF JUSTICE

RAPE AND ITS VICTIMS: A REPORT FOR CITIZENS, HEALTH FACILITIES, AND CRIMINAL JUSTICE AGENCIES

By

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FOREWORD

The woman who is raped is doubly victimized—first by the attacker and again by the attitudes of society. Until very recently, sexual attacks and their aftermath were not even topics for open discussion. But that has changed, partly through the initiative of concerned citizens. With that change has come the opportunity to analyze and improve the treatment of the rape victim.

Rape and Its Victims looks at promising developments in treatment around the country and presents guidelines for police, prosecutors, hospitals, and citizen action groups. The National Institute believes this manual can contribute to more enlightened and sensitive procedures in an area heretofore characterized by a preoccupation with the credibility of the victim rather than her needs.

Gerald M. Caplan,
Director

PROJECT TEAM

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PREFACE

Until recently the crime of forcible rape and its consequences for the victim had received little attention. But with the growing anxiety about all forms of violence in our society, which has reached segments of the population heretofore untroubled by the threat of crime, the rising incidence of rape has emerged as a problem of national dimensions.

Much of the recent attention has been stimulated by citizens concerned with equalizing the status of women. The women's movement has often focused on the inequities inflicted upon victims of rape.

Rape is one of the ugliest of crimes. Its very nature is humiliating to the victim, and it is frequently accompanied by violence, forced sodomy, and similar acts that additionally traumatize and humiliate. The victimization of the woman does not necessarily cease with the termination of the attack itself. Pregnancy, venereal disease, hospitalization, loss of employment, imputations of wantonness, and even ostracism by family or neighbors may follow.

Should the victim report the offense to the police, her suffering may be continued or even exacerbated by the justice system. She may be exposed to police skepticism, tactlessness, or outright prurience; inadequate, delayed, or nonexistent medical care; and the need to repeatedly describe details of the attack to a seemingly endless assortment of police, doctors, prosecutors, judges, and most, if not all, of whom are men. If she should continue her cooperation to the point of trial, court rules can open her chastity, character, and choice of companions to scrutiny and, often, disparagement. And, after all the victim's anguish, defendants in rape cases are seldom convicted as charged.

Citizens' activities to increase public awareness of these problems have brought about efforts to reform various laws, to improve medical treatment for rape victims, and to encourage police departments and prosecutors' offices to examine their procedures in the investigation and prosecution of rape cases.

This book is addressed to police administrators, hospital administrators, prosecutors, and citizens involved in community action who are prepared to re-examine their agencies' response to cases of rape. It provides information and analysis to spark such a review and outlines suggestions for coping with problems that commonly hinder change. The discussion is confined to forcible rape of adult women, generally defined as the carnal knowledge of a female through the use of force or the threat of force by a male other than her husband.

The book is divided into four sections: "The Police Response," "The Response of Medical Facilities," "The Response of Prosecutors' Offices," and the "Response of Citizens' Action Groups." The material presented in each is based upon the findings of national surveys conducted among each of these four groups, with special emphasis placed on agencies that have begun innovative changes in their approach to cases of rape. Each section presents findings from these nationwide surveys and then suggests guidelines for others seeking ways to improve their procedures in such cases. Insights gained from monitoring rape victim projects or innovations underway in six jurisdictions are presented in Appendix V.

A basic finding in these studies was that the functions of police departments, hospitals, prosecutors, courts, and citizen groups are highly interdependent. The procedures of each one greatly influence all of the others. One need only consider the influence rape crisis centers may have on a victim's decision to report the crime to the police, or the role of physicians in the collection of evidence, to recognize that law enforcement's success is often heavily influenced by other institutions and organizations.

The attempt has been to identify programs, techniques, procedures, and policies that appear to be constructively innovative, especially effective, or otherwise valuable in coping with the problem, and which therefore might be suitable for transfer and replication in other jurisdictions. In addition to the guidelines in each section, the appendixes contain materials that may be used as sample forms for police and hospital procedures or that augment the discussion of such topics as the police interview of a rape victim, counseling for rape victims, and legal issues being raised by rape law reformists.

Because law enforcement agencies, medical facilities, and community groups are revamping their approaches to the control of rape at a rate that would have been inconceivable only a few years ago, the findings and the guidelines in this book cannot be considered conclusive. Undoubtedly, new rape programs have come into being since the 1974 surveys, and their new developments may not be reflected here. In addition, almost none of the reforms that have been made have been either supported or repudiated by hard evidence. The results of careful, empirical research in this field are still lacking. Therefore, the assessments presented here should be viewed as informed judgments that await revision as more vigorously developed information becomes available.

SECTION 1

THE POLICE RESPONSE*

---

*Research performed by Blackstone Associates, Washington, D.C.

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CHAPTER I. INTRODUCTION

Law enforcement agencies fully understand that rape is a very serious felony—as is, say, armed robbery. But, because of the mythology surrounding rape and its relatively infrequent incidence (of major crimes, only homicides take place less often) police traditionally have been reluctant to treat rape as a crime of first priority. Yet consider:

> Rape is one of the most brutal of all crimes. As Bard and Ellison make clear (see their article, Appendix I-B), rape victims need sustain no physical injury to suffer severe and lasting pain; few crimes are better calculated to leave their victims with lasting psychic wounds.
>
> Rape is one of the most feared of all crimes. Only murder ranks higher, as indicated both by the severity of the law's sanctions and by studies of the public's ratings of various crimes.
>
> By its nature rape is unusually difficult for police to prevent or stop.
>
> Rape holds two unenviable records in recent FBI *Uniform Crime Reports:* it is the fastest growing of the Index crimes against the person; and among these it has the lowest proportion of cases closed by reason of arrest.

In short, as Bard and Ellison put it, rape is the "ultimate violation of self (short of homicide)." Moreover, because police are nearly always the first official representatives of society to deal with a rape case, improving the justice system's response falls most heavily on law enforcement agencies.

The materials that follow are based upon a national survey of more than 50 police departments conducted by Blackstone Associates in 1974. The chapter on survey findings reviews innovations in patrol response to rape, investigative procedures, and other practices related to the handling of rape cases. The last chapter of this section presents guidelines developed from the survey findings, as well as from substantial amounts of information and advice provided by a panel of detectives, police trainers, and others experienced in dealing with rape cases; our colleagues working on different components of this project; plus suggestions from several officers consulted on an individual basis. Although the literature relevant to the police response is not extensive, the guidelines also reflect insights gleaned from readings and documents.

This section assumes a familiarity with principles of police organization, functions, and terminology that lay persons may not share. A glossary is appended to aid readers who are not police officers. In addition, a bibliography refers to several texts helpful in grasping the basic principles of police operations.

Because police administrators are busy people with little time for theory or abstruse analysis, the survey findings stress straight-forward description at the expense of interpretation, and the guidelines avoid lengthy argumentation and supporting documentation. The goal was to emphasize basic principles rather than detailed, step-by-step procedures.

Police forces, traditionally all-male institutions, have in recent years been hiring increasing numbers of women. One position frequently filled by women is that of sex crimes investigator. Every specialized unit responsible for the investigation of rape visited during this project was composed of both male and female investigators, although this was not the case for investigative units for other crimes.

The crime of rape necessitates a "systematic" response from police agencies. That is, in reacting to a report of rape, the more effective law enforcement agencies put in motion a series of activities engaging several different units within the department and involving a number of variably integrated procedures. Tactful treatment of the victim by the police officer, for example, facilitates the detectives' work; good lab procedures are needed to make use of carefully collected evidence; the better the system for sharing information among patrol and investigative units, the higher will be the rate at which rapists are identified and arrested.

At the same time it must also be reported that few departments appear to give primary attention to the systematic aspects of their response to rape. Instead, the survey encountered a proliferation of narrowly focused efforts. Among those most commonplace are the establishment of specialist sex crimes squads, the assignment of women officers to investigate rape, and the development of special training courses.

The point is not that reforms of this kind are not valuable. The pragmatic urge to begin with innovations that are relatively straightforward or to defer more comprehensive (and more challenging) changes is understandable. However, both the pluarity of relevant police actions and the complexity of their interrelationships should not be lost sight of in the interests of shortrun expediency. For this reason, then, this book outlines a "systems" approach.

The guidelines are not equally applicable to all police agencies; they are geared to urban departments of medium-to-large size. Even in this group, police departments vary widely in the support services and other resources available and in their internal organization. Wherever feasible, therefore, the guidelines offer alternative approaches. These alternatives do not attempt to account for all possible variations; instead, they set forth techniques likely to be within the means of smaller departments.

Three postulates governed the design of this project. The first was that society's current response to the crime of rape is seriously deficient; on this score there was ample documentation from a number of sources including the FBI's *Uniform Crime Reports*, law journals, the press, national television, task force reports, and feminist literature. Second, a variety of reforms, although geographically scattered, little known, and often of recent origin, were underway. A critical corollary to this assumption was that at least some of these innovations had been in existence long enough to have developed a body of experience potentially valuable to concerned administrators in other jurisdictions.

As might be expected, the evidence supporting this second postulate (and its corollary) was far more limited than for the first. And even less well documented was a third assumption: that a substantial audience for information and guidance on promising developments existed among police and other officials.

These three hypotheses determined the project's goals and methods. Instead of sampling the total spectrum of police agencies, an approach likely to turn up a good deal of already available information about practices in need of improvement), the project examined a representative sample of innovative programs already in place. The aim was to be more pragmatic than scientific and to research new police processes in rape investigation, rather than to systematically sample the full range of police procedures and their relative frequencies.

The survey was conducted in three phases During Phase I, the project's staff contacted individuals by personal visit or by telephone and organizations deemed likely to know of departments undertaking promising or unusual programs. Having explained the objectives, the staff requested their informants to notify them of any significant developments. Law enforcement specialists at LEAA's national headquarters and all regional offices were polled. The International Association of Chiefs of Police, the National Sheriff's Association, and the Police Foundation were contacted, as were the State Planning Agencies and LEAA-funded local criminal justice coordinating councils. Additional leads were developed through a notice published in several law enforcement journals and by a review of popular and technical literature.

This search identified 51 departments reportedly employing (or developing) some innovative or progressive methods. During Phase II, one or more officers in each of these departments were interviewed, in most cases by phone. A checklist was used in every interview to insure thoroughness and uniformity of coverage. If the officer seemed unsure of facts, too busy, or otherwise appeared to be an unsatisfactory respondent, a return call was made, or a second officer was contacted. Although most departments lacked such materials, relevant training outlines, special orders, progress reports, news clippings, and other such documents were collected.

Thereafter, 10 criteria were established for selecting 10 to 15 departments to which site visits could be made. Departments of different sizes and organizational structures, whose technical and support services reflected alternative functional responsibilities of the units involved in rape cases, were selected. Older, more established sex offense investigative units, as well as newer pilot projects, were sought. In addition, departments exhibiting special concern for the staffing and training of sex offense units received special study. Departments with investigative units stressing cooperative interaction with other criminal justice, social service, and medical agencies also had priority. Selection was made by two staff persons who independently screened all the interview reports and supporting documents, using the 10 review standards. Thirteen departments were chosen for site visits.

Detailed checklists were prepared for the site visits. The lists and the procedures for using them under field conditions were tested in visits to three police departments.

The 13 site visits took place in the summer of 1974. Each visit lasted from one to three days, with the shorter visits taking place at the smaller departments.

Departments Contacted

Akron P.D., Ohio
Albuquerque P.D., New Mexico
Ann Arbor P.D., Michigan
Austin P.D., Texas
Baltimore P.D., Maryland
Boston P.D., Massachusetts
Buffalo P.D., New York
Cambridge P.D., Massachusetts
Chapel Hill P.D., North Carolina
*Chicago P.D., Illinois
Cincinnati P.D., Ohio
Columbus P.D., Ohio
Dallas P.D., Texas
Dayton P.D., Ohio
East Greenbush P.D., New York
*Ft. Lauderdale P.D., Florida
Indianapolis P.D., Indiana
Jacksonville P.D., Florida
Kansas City P.D., Missouri
Long Beach P.D., California
*Los Angeles P.D., California
*Los Angeles County Sheriff's Department, California
Louisville P.D., Kentucky
Lynn P.D., Massachusetts
Madison P.D., Wisconsin
*Metropolitan P.D., Washington, D.C.
*Minneapolis P.D., Minnesota
Minneapolis County Sheriff's Department, Minnesota
Nashville P.D., Tennessee
New Bedford P.D., Massachusetts

Departments Contacted—Continued

- New Orleans P.D., Louisiana
- *New York P.D., New York
- *Oakland P.D., California
- Omaha P.D., Nebraska
- Palo Alto P.D., California
- Pasadena P.D., California
- Philadelphia P.D., Pennsylvania
- Pittsburgh P.D., Pennsylvania
- Portland P.D., Oregon
- Rochester P.D., New York
- Sacramento P.D., California
- *San Diego P.D., California
- San Francisco, California
- *Seattle P.D., Washington
- Simi Valley P.D., California
- Stillwater P.D., Oklahoma
- *St. Louis P.D., Missouri
- *St. Paul P.D., Minnesota
- Toledo P.D., Ohio
- *Tucson P.D., Arizona
- Worcester P.D., Massachusetts

*Denotes site visit.

CHAPTER II. INNOVATIONS IN THE CONTROL OF RAPE: FINDINGS OF A SURVEY OF POLICE PROGRAMS

A. Investigation

Every police department visited has elected to specialize its investigative services to the extent of forming sex offense units or combined units for sex crimes and other violent crime investigation. Departments report that this division of labor results in a more efficient handling of caseloads and provides a consolidated base of information and expertise. In addition, it is believed that experienced sex crimes investigators are more skilled in handling the needs and reactions of rape victims.

With few exceptions, the formation of specialized sex crimes squads is a recent phenomenon. However, some departments have recently redesigned their sex crimes investigation units to include, among other innovations, more emphasis on sex crime patterns and identification of the recidivist rapist.

This specialization is in part a response by departments to some internal police problems in the handling of rape cases. However, in some more recent changes, members of concerned community groups have worked with interested police officers to substantially influence departments' treatment of rape victims. In addition, other citizen's groups have employed adversarial approaches with variable success. For a further discussion of the dynamics of police and citizen interaction, the reader should review the portions of this book that discuss rape crisis centers.

1. *The structure of investigative units.* The organization of sex crimes investigation units varies considerably. The form chosen depends largely on a jurisdiction's crime rate, geographical area, and the type and extent of investigative services used by each department. Different forms have evolved, including combined units responsible for investigating crimes against the person, a single sex offense squad, and a network of specialized units with research components.

Some police departments have combined units that investigate homicide and sex crimes. Each member of these combined units investigates both types of cases. These departments believe that the similarity in the investigative process for both crimes and the crime rate are such that this arrangement provides the most effective use of the work force.

In contrast, other police departments have one specialized unit to investigate sex crimes. In these jurisdictions, the number of rapes and other sex crimes is high enough to sustain a specialized staff, and there is need to consolidate information on crime patterns and modus operandi of offenders.

A number of police departments in larger cities feel that decentralized units are more efficient for handling rape cases. San Diego has one specialized unit in an area with a high rate of sex offenses and two more generalized units for areas with lower rates. The New York, Chicago, and Los Angeles police departments, with larger geographical areas to cover and more information to analyze and disseminate, have turned to even greater decentralization by adding research sections. The New York City Police Department (NYCPD) has established four specialized sex offense investigative units. The Chicago Police Department's six area headquarters each house a sex-homicide unit in which one or two investigators are responsible for sex crimes investigation.

Similarly, the Los Angeles Department, which must cover a widely dispersed population, has 17 divisions containing units concerned with crimes against the person, each having one or more rape investigation teams.

In New York, the Sex Crimes Analysis Unit, the NYCPD's research and coordination section for sex crimes, is equipped with a special telephone number for both emergency and delayed rape reports. When a rape victim asks to speak to a female officer, members of this unit may respond if no female investigator from an area unit is available. This unit is also responsible for working with victims during follow-up investigations to establish the identity of the offender. In contrast, the comparable units of the Los Angeles and Chicago departments do not deal with the investigation of rape cases, but serve only analysis and dissemination functions.

2. *Qualifications of investigators.* Recruitment of personnel into specialized squads responsible for investigating sex offenses is largely an informal process. While criteria revolve around experience and sensitivity, there are few standard qualifications, and training of new investigators is often accompanied by tutelage alone.

Most sex crimes investigation units require that recruits into the squad have at least three or four years of patrol and investigative experience. Until recently, this qualification has been waived for female sex crimes investigators. Some departments have recruited women without patrol experience into investigative positions. This policy was initiated because of the lack of women who had served patrol duty and to meet departmental priorities for having women in sex crimes investigative units. However, with the increasing number of female patrol officers and laws prohibiting sex discrimination, this practice is on the decline.

All the departments visited for this project claimed that sex crimes investigators are recruited on the basis of their sensitivity and attitudes, but the evaluation of these qualities in recruits is highly subjective. No department reported that systematic audits of candidates' records are made to determine the officer's ability to treat victims sensitively. In fact, it is standard operating procedure for the supervisors of the sex crimes unit and the investigative bureau (the personnel responsible for recruitment) to rely on a personal interview, the officer's reputation, and perhaps the recommendation of the candidate's commanding officer to make this determination.

Departments that have had sex crimes units for many years generally provide no formal training for recruits into the unit. However, the Metropolitan Police Department in the District of Columbia annually conducts a multidisciplinary, two-week seminar on all aspects of rape investigation. New members of the Sex Offense Branch and investigators from other nearby departments attend. In some more recently established units, sex crimes investigators have been given specialized training courses and seminars in sensitivity, law, evidentiary matters, and interviewing techniques.

a. *Sex of the investigator.* Police forces, traditionally all-male institutions, have in recent years been hiring increasing numbers of women. One position frequently filled by women is that of sex crimes investigator. Every specialized unit responsible for the investigation of rape visited during this project was composed of both male and female investigators, although this was not the case for investigative units for other crimes.

While including women investigators in sex crimes investigative units has become standard practice, a controversial issue has been the relative sensitivity of male and female investigators in their treatment of rape victims. With no hard data to prove that either sex is more attuned to the problems of victims, responsibilities for various investigative duties are either shared or divided according to the preference and beliefs of individual sex crimes units.

While some departments have policies that women should interview rape victims because they are more sensitive to the victims' needs and can elicit more information with less embarrassment to the victim, in others, the men and women share equal responsibility for interviewing and field work. These departments claim that the sex of the interviewer is less important than sensitivity and experience. In sex crimes units where all responsibilities are shared, a woman will generally interview the victim if the victim requests it or if there is some other problem that requires it. Of the departments visited, only the New York area sex crimes units try to work in male and female teams whenever possible to cover such contingencies.

3. *The scope of sex crimes investigation.* Sex crimes investigative units differ not only organizationally, as discussed above, but also in the kinds of investigations they conduct. Whether investigators become involved in a rape case immediately after it is reported or work only on follow-up investigation is a major question. The way each department answers it appears to be an expression of the priority it assigns to the problem of rape and reflects its underlying assumptions about the relative capabilities of patrol officers and special investigators.

To a large extent, the rate of sex crimes in a jurisdiction dictates whether a department will have a special rape investigation unit. Then subsidiary issues–size, working hours, and the amount and type of departmental resources available to the unit–reflect the relative importance of the unit to the department's leadership.

In general, police departments that rely totally on the patrol force for the preliminary investigation of rape have sex crime units that operate only during daytime hours. They believe their patrols are well trained to handle initial investigation of rape. These departments report that investigators can make best use of their time for interviews and court appearances during the daytime hours.

In contrast, departments electing to have sex crimes investigators respond immediately to a report of rape tend to have sex crimes squads on duty on a 24-hour basis. Because most rapes occur at night and follow-up investigation must usually be conducted in the daytime, continuous operation of the investigative squad is a necessity for this system. While this may be accomplished by keeping a unit continually staffed, an alternative is an on-call system for investigators on nights and weekends. Although this procedure is used in one jurisdiction we visited, it is not practical for most departments. It is expensive, objected to by unions, and creates administrative problems. These problems, however, are not insurmountable. For example, New York's Sex Crimes Analysis Unit female investigators have been able to be available at night by working on a voluntary reserve system.

Table 1 summarizes variations in the types of sex crimes investigative units, their caseloads, and their staffing for the 13 police departments visited.

a. *The initial investigation by patrol.* The majority of police departments contacted rely on patrol officers to conduct the initial investigation of a rape case. However, most of the sex crimes investigation units can be contacted by patrol for assistance in complicated cases or when a report fits a pattern of cases in which investigators are interested. While these specialized investigative units are scheduled to work during the day, they are generally flexible enough to work on special cases when necessary.

Reports of rape phoned into the police immediately after the offense receive high priority attention from patrol. In such cases, rapid response to the crime scene or to the location of the victim increases the probability of apprehending an offender and securing fresh evidence necessary to prosecute a rape case.

Certain functions performed by patrol in these cases are common to all departments surveyed. For example, officers first arriving on the scene initially assess the victim's need for emergency medical treatment. Except in cases where the victim is in need of immediate hospitalization, officers secure the crime scene, obtain a "lookout" (radio broadcast of the offender's description, weapon, car, direction of flight, etc.) or an improved "lookout" if some description has already been disseminated by the

Table 1. Comparison of Staffing and Workload in Selected Sex Crime Investigative Units

Department/ Investigative Unit	Female Population[1]	No. of Rapes[2]	No. of Rapes per 100,000 Females	Other Crimes Investigated[3]	No. of Staff	Working Hours[4]
St. Paul Sex-Homicide Unit	165,071	92	55.7	All crimes against the person-except robbery	1 captain 9 sergeants	9:00 a.m. to 9:00 p.m. (overlapping shifts)
San Diego Sex Crimes Detail	337,790	173	51.2	Sex-oriented assault and kidnapping, child-molesting, indecent exposure, some homosexual cases	1 sergeant 3 detectives 2 policewomen	7:00 a.m. to 4:00 p.m.
Seattle Morals Unit	276,438	276	99.8	All sex crimes	1 sergeant 4 or 5 detectives	7:00 a.m. to 3:45 p.m.
Minneapolis Sex Division	235,555	236	100.2	All sex crimes	2 lieutenants 2 special investigators	Daytime
Oakland Assault Detail	187,868	220	117.1	All sex crimes	2 sergeants 1 policewoman	8:00 a.m. to 4:00 p.m.

[1] 1970 Census figures. Information obtained from the U.S. Bureau of Census, Statistical Information Branch.
[2] All figures taken from *Uniform Crime Reports*, 1973.
[3] "All sex crimes" excludes prostitution and other forms of vice.
[4] These figures do not reflect the immediacy of the response; some units respond as soon as possible, others respond as late as 24 hours later. See the text for discussion.

Department/ Investigative Unit	Female Population[1]	No. of Rapes[2]	No. of Rapes per 100,000 Females	Other Crimes Investigated[3]	No. of Staff	Working Hours[4]
Ft. Lauderdale Homicide Division	73,973	75	101.4	All crimes against the person except robbery	1 detective-sergeant 4 detectives	Daytime, called out at night for homicide & rapes
Tucson Sex Crimes Detail	13[illegible],330	84	61.6	All sex crimes	1 sergeant 3 investigators	8:00 a.m. to 4:00 p.m., on call 24 hrs./day
St. Louis Sex Offense Investigative Unit	338,769	565	166.8	All sex crimes	1 sergeant 10 patrol officers	24 hrs./day
District of Columbia Sex Offense Section	405,019	596	147.2	All sex crimes	1 captain 2 lieutenants 4 sergeants 24 investigators	24 hrs./day

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[1] 1970 Census figures. Information obtained from the U.S. Bureau of Census, Statistical Information Branch.

[2] All figures taken from *Uniform Crime Reports*, 1973.

[3] "All sex crimes" excludes prostitution and other forms of vice.

[4] These figures do not reflect the immediacy of the response; some units respond as soon as possible, others respond as late as 24 hours later. See the text for discussion.

Department/ Investigative Unit	Female Population[1]	No. of Rapes[2]	No. of Rapes per 100,000 Females	Other Crimes Investigated[3]	No. of Staff	Working Hours[4]
New York Area Sex Crimes Squad	4,191,507	3,735	89.1	First degree sex crimes and attempts	1 lieutenant 2 sergeants 23 investigators per squad (4 squads)	8:00 a.m. to midnight. Sex Crimes Analysis Unit female police officers voluntary reserve system operates at night.
Los Angeles Investigative Divisions	1,459,437	2,146	147.0	Variable according to division size	Variable according to division size (17 divisions)	24 hrs./day (Specialists work daytime hours)
Los Angeles County Sheriff's Detective Bureau	3,630,256	736	20.3	Variable according to station size	Variable according to station size (16 stations)	24 hrs./day
Chicago Homicide Sex Units	1,764,285	1,619	91.8	All crimes against the person except robbery	1-2 sex crimes specialist investigators in each of 6 areas	24 hrs./day

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[1] 1970 Census figures. Information obtained from the U.S. Bureau of Census, Statistical Information Branch.

[2] All figures taken from *Uniform Crime Reports*, 1973.

[3] "All sex crimes" excludes prostitution and other forms of vice.

[4] These figures do not reflect the immediacy of the response; some units respond as soon as possible, others respond as late as 24 hours later. See the text for discussion.

dispatcher, and initiate the search for an offender.

Beyond these functions, however, the responsibilities of patrol vary. Where sex crimes investigators and other support units (such as a mobile crime lab or tactical squad) systematically respond to rape cases, the patrol function is generally more limited than when no such assistance is available. This generally entails a more cursory interview of the victim and less responsibility for the collection and preservation of evidence.

Similarly, the availability of support units has some bearing on the need for patrol supervisory personnel at the crime scene. For example, supervisors in the District of Columbia and Tucson will generally respond to a rape crime scene to coordinate and supervise the activities of patrol and support units. In Seattle and Minneapolis, supervisors generally respond only at the request of patrol officers because rarely are support units available. In some cities, such as Los Angeles and Chicago, supervisors may be less available to go to a rape crime scene because of a high rate of other priority calls.

Because specialized training is needed for the collection and preservation of evidence at the scenes of major crimes, some police departments have trained some of their patrol officers as "evidence technicians" to process crime scenes, including those of rape. These officers are responsible for transporting and insuring the safety of evidence in some jurisdictions. The use of evidence technicians is seen by these departments as an efficient and effective means of properly retrieving evidence. In addition, it releases the crime laboratory and sex crimes investigators for other functions.

Contrasting beliefs on the use of evidence technicians were expressed by other departments. Some investigators claim that bringing additional patrol officers to the scene of a rape, where there is a tendency to overload the area with personnel, only complicates the coordination of activities and produces problems in the number of officers who will have to testify in court.

In general, departments that use patrol officers acknowledge that crime scene investigation of rape and the subsequent hospital examination of the rape victim necessitate keeping these officers out of service for lengthy periods. While this strains the work force, it is felt that this is part of the patrol function. Furthermore, it enables sex crimes investigators to devote more time to the follow-up function, which is beyond the province of patrol.

Although some sex crimes investigators claimed that their presence at the rape crime scene is unnecessary because patrol officers are capable of making the initial report, other investigators are dissatisfied with this procedure. They reported a need to be involved in the initial stages of the investigation, but felt that budgetary problems and a lack of personnel made it impossible for them to be available around the clock to respond to the scene of a rape.

Regardless of the length of time between a rape and the report to the police, patrol is generally responsible for the preliminary investigation of the case. Unless a victim walks into a police station and asks to speak to an investigator, most sex crimes investigators will not take the initial report from the victim.

Most departments state that if a rape is reported within a few hours of the offense, the basic procedures of patrol do not vary greatly from those used when the report is immediate. However, support services, the patrol supervisor, and sex crimes investigators may not be summoned to the crime scene. The principal difference is that the report receives lower priority for immediate response, and patrol officers may spend more time at the scene of the crime before taking the victim to the hospital.

In cases where a report is delayed by a substantial amount of time or evidence has been destroyed, the functions of patrol are largely lost. Although patrol is still sent to the victim to take an initial report, extensive interviews with the victim are left to the sex crimes investigators. Although patrol generally spends less time out of service in cases of delayed reports of rape, these cases are particularly frustrating to patrol and investigators. Despite the fact that victims often have valid reasons for waiting before calling the police, the chances of a successful investigation and prosecution are greatly diminished unless the victim knows her assailant.

b. *The initial investigation by specialized investigators.* In the belief that early use of the expertise of specialized investigators will increase the probability of a successful resolution of a rape case, some departments dispatch sex crimes investigators to the scene of the cime immediately after the offense is reported. While patrol officers obtain the initial description needed for a radio broadcast and see to immediate medical needs of the victim, it is the responsibility of the sex crimes investigators to interview the victim in more detail.

Investigators of sex crimes units that respond to rape calls 24 hours a day, such as in St. Louis and the District of Columbia, believe that having first-hand knowledge of the crime scene and the victim's reaction gives them a better indication of what occurred and what is important for their investigation. By being at the scene they can spare the victim from repeating her account of the offense twice, and they are better able to build rapport with her if they enter the case at this stage. These investigators can also oversee the evidence collection and preservation process to insure that it is properly carried out. And, if specialists take over this responsibility, the patrol force can be more efficiently used to perform their regular duties, in which they have had more training and experience.

Other departments, which may acknowledge the advantages of using special investigators, don't have the work force or resources to provide continuous staffing of a sex crimes unit. Various compromises are made. For example, the Tucson squad is on duty during daytime hours only, but at least one investigator is on call at nights and on weekends.

The Ft. Lauderdale Police Department attains the same goal by having its Homicide Unit, responsible for the investigation of rape, respond to the scene during the day. Generalist investigators work the night shift, and if a rape is reported at night, the Homicide Unit supervisor is called in. He has the option of calling in the homicide investigators or working with the generalists. Investigators rotate through the detective bureau to get experience in all areas. This system uses the work force efficiently and creates no extra expense.

New York provides 24-hour investigator coverage for rape reports in a similar manner. The four sex crimes investigative units respond to rape reports until midnight, after which generalist detectives take over. If a rape victim asks to speak to a female officer, or if problems arise, the member of the Sex Crimes Analysis Unit on duty through the voluntary reserve system can be summoned. Additionally, a member of the unit is always on duty at night and can provide advice to generalist detectives. This system works at little extra expense for the department, and experienced interviewers are always available when needed.

Despite the advantages enumerated, several drawbacks have been encountered in having sex crimes investigators respond to the rape scene. One problem is the time lag between the patrol response and the arrival of investigators. Because patrol officers are instructed not to question the victim about the details of the rape, and because only limited numbers of investigators are available to respond to rape reports, a period of time elapses that is often awkward for both the victim and the officer.

4. *Obstacles to successful investigation.* The investigation of a rape case entails numerous problems not necessarily inherent to other serious crimes. One obstacle to successful investigation is the fact that the rape victim may be a

reluctant complaining witness. Several evidentiary issues may also present problems.

Many rape victims do not choose to report the crime to the police, others delay making a report. While the victim may have perfectly understandable reasons for delaying her report of the offense, any delay decreases the probability of apprehension of the suspect (unless the victim knows her assailant, which occurs in a minority of cases). Prolonged delay of a report results in stale evidence that is useless for investigators.

Even when a victim reports a rape promptly, it may be difficult to maintain her cooperation during the long investigation and prosecution processes. The victim must relate intimate details of the offense to a series of officials, a difficult, unpleasant process. Even if the victim wants to cooperate in the investigative process, she may have considerable pressure from family and friends to withdraw cooperation and avoid the stress and embarrassment of the public trial process.

The type of evidence and information necessary to prove that a rape was committed is a problem for investigators. Because few rape victims are externally bruised or battered, it is often difficult to prove the element of force needed for a rape conviction. Medical evidence from a pelvic examination is not always available, nor is it conclusive. The majority of reported rapes are stranger-to-stranger crimes,[1] and many victims cannot identify their assailants in lineups or photograph files of known sex offenders, nor can they describe the rapist sufficiently well to have an accurate composite picture or artist's sketch produced. The identification process is further hindered by the fact that the use of informants in rape cases, unlike some economic and violent crimes, usually is not fruitful except in cases of gang rape.

To overcome these obstacles, sex crimes investigators have had to work within limited technology to devise various strategies for identifying suspects and treating rape victims sensitively. These strategies depend upon technological resources, investigative units' preferences, and whether or not investigators respond to the rape scene.

a. *Identifying the suspect.* The majority of sex crimes units prefer to have a suspect in custody and hold a lineup for identification rather than attempting to have a rape victim make a street identification shortly after the offense. Many sex crimes investigators believe that on-street identifications are untrustworthy, because the victims' emotional condition may confuse her and because comparisons are necessary for a good identification.

However, some sex crime investigators, such as those in Tucson and the District of Columbia, prefer to hold on-street identifications when possible. Because they are at the scene with the victim, they can prepare her for the identification, insure that it is held within a reasonable time after the offense, and make sure that it is conducted properly. Furthermore, they believe that if little time has elapsed since the offense the victim has a better chance of recognizing her assailant.

Only a minority of rape victims know the identify of their assailant. Sex crimes investigators have the responsibility to establish the identity of a rapist in the vast majority of cases, yet they are ill-equipped to do so. Technological resources of many departments are extremely limited, and few alternative techniques are available.

A major presumption in sex crimes investigation is that rapists are likely to be recidivist sex crime offenders, and, therefore, it is believed that there is a good chance their identity is known to the police. While some effort is put into establishing the identity of the opportunistic rapist, the bulk of identification techniques are geared to the offender guilty of multiple rapes.

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[1] Duncan Chappell and Susan Singer, *Rape in New York City: A Study of Material in the Police Files and Its Meaning* (in press), Table VI; and Thomas A. Giancinti and Claus Tjaden, *The Crime of Rape in Denver* (unpublished paper for the Denver Anti-Crime Council, 1973), p. 4. These studies report that 71.7% of the rapes studied in New York City and 67.1% of the cases in Denver were stranger-to-stranger rapes.

For this reason the majority of sex crimes investigators maintain photograph ("mug shot") files of known and suspected sex offenders. Some departments rely heavily on the rape victim's ability to identify her assailant by using these files. To remedy the conditions that contribute to victim uncertainty in viewing mug shots, a computerized mug shot file may be used. For this, a list of offender characteristics is fed into the system and a limited number of pictures is shown on a screen. Another variation is enlarged polaroid pictures that look less similar to each other than mug shots.

Several departments employ alternative procedures. For example, the Identi-Kit, used to make composite pictures by fitting together sketches of facial features, is a newer identification technique used by some departments. These sketches are then disseminated to patrol and are compared to mug files of known sex offenders fitting that general description. Police artists' sketches and the Photo-Kit, composite pictures made up of black and white photographs of facial features, are used by some departments as alternatives (or supplementary aids) to mug shot identification.

Some departments are developing computerized files containing offender characteristics and modus operandi variables assembled from reports of sex offenses. This information is compiled for suspect identification and for the identification of patterns of rape. A few departments are planning to develop computerized modus operandi files for rape, but most other departments have been unable to afford this resource.

In summary, while the departments surveyed operate under the assumption that many rapists are known recidivists, the technology necessary for identifying these rapists is poorly developed. With the exception of a few departments, modus operandi files consist of little more than photographs and sketches for offenders and, in some cases, cross-indexed file cards containing offender characteristics and minimal descriptions of the type of rape committed. In many cases the investigator's memory is relied upon, rather than systematic compilation of data useful to the identification of the rapist.

b. *Interviewing the victim.* The majority of departments contacted require that sex crimes investigators take a formal statement from the rape victim about the details of the offense. While a detailed chronological account of the offense and description of the offender is the standard format, the procedures and circumstances for obtaining it vary. Other departments obtain equivalent information, but do not require formal statements from victims.

Many sex crimes investigators believe that formal statements are necessary because they provide precise information helpful to investigation and prosecution. The statements prevent gaps in the investigative process and help the prosecutor determine what questions to ask the victim. Some investigators also believe that taking these statements is helpful in estimating how the victim will conduct herself in court. A written statement is claimed to be beneficial for the victim because it spares her having to repeat the entire account to several investigators. Moreover, if the case goes to trial, lengthy delays are involved and some investigators feel it is helpful to the victim to have this document to refresh her recollection of the information given to the police and the trial attorneys.

Other departments do not require a written statement from the rape victim. Officers and investigators include all information in preliminary and supplementary reports. Sex crimes investigators in these departments believe that formal statements are unnecessary because the original and supplementary offense reports contain much of the narrative that the victim tells to the officers. If the case goes to trial, these reports are made available to the victim for review before her court appearance.

The timing of the victim interview depends on the emotional and medical condition of the victim, the working hours of the sex crimes investigators, and the time that the rape occurred. If a suspect is apprehended, investigators like to get the statement or conduct the interview as soon as possible because this information must be included in the prosecution papers, but if no suspect is in custody, arrangements can be more flexible.

In the majority of departments visited, interviews with the victim and victim statements are taken in a private room at police headquarters. This protects the privacy of the victim and makes it possible for a secretary to record the statement verbatim. However, some investigators often interview the victim at her home so that she will not feel uncomfortable or be distracted by police surroundings.

Most investigators will not allow other persons to sit in on this interview. They feel they are competent to handle the interview and are sensitive to the victim's problems, and they believe having another person present will not assist the victim, but may interfere with the interview.

In some cases, however, another person may be allowed to sit in on the interview if the victim requests. One police department with two advocates to assist victims of violent crime allows the advocates to be present at the request of the victim or the investigator.

In another flexible and innovative program, many victims come in for the interview with an advocate from a rape relief program or the medical center. If the victim is alone and problems arise in the course of the interview, investigators may call one of these centers and ask for an advocate. This unique arrangement is beneficial to the investigator's need for information and the victim's need for support.

Although victim statements are considered useful by some investigators, there are a number of problems associated with their use.

For example, where patrol officers take detailed information, victims must repeat the entire account to a sex crimes investigator. Even where investigators go to the scene of the rape, victims often must give a formal statement to another investigator.

Another problem arises with respect to the victim's statement in court. Where statements are taken, they should become part of the prosecution papers, which may be disclosed to the defense attorney, together with the investigator's original notes. Some of the details of the statement invariably differ from successive police reports, and this enables the defense attorney to attack the credibility of the victim in court. Investigators claim that these differences in reports are mainly omissions rather than contradictions and that this is not fatal to the prosecution. Nevertheless, this variability in victim statements and police reports leaves the victim vulnerable to attack in court despite her efforts to comply with police procedure. Interviews with victims in which information is merely included in police reports are less conducive to defense attorney attacks in court, since discrepancies in the record may be due to the investigator rather than to the victim.

c. *"Unfounded" rape reports*. The reasons for calling a rape case unfounded vary among police departments, as do the methods for unfounding. The credibility of the rape victim is questioned more than that of any other victims of crime. This extraordinary concern for the authenticity of rape complaints is manifested in the FBI's *Uniform Crime Reports*—forcible rape is the only crime for which an "unfounded" rape is calculated.

Some of the reasons reported by sex crimes investigators for false rape complaints are that the victim is seeking revenge, that she is pregnant and unmarried, or that she stayed out all night and has no excuse for her parents. Several investigators claimed that most false complaints are filed against particular individuals; others stated that no one in particular is accused in most cases.

Most investigators prefer to obtain an admission from the victim that the crime never took place or that she consented to sexual intercourse before unfounding a case, but rape cases can be unfounded when the physical evidence contradicts the victim's account of the offense or when there is other credible information indicating that a complaint is false.

One method used to determine the truthfulness of complaints is a polygraph examination. Most departments claim that this technique is rarely used; either it is seldom necessary or the department does not have the equipment and a skilled operator. Only one department has employed the polygraph on victims as standard operating procedure, and it does so only at the request of the prosecutor's office, which believes that the stiff penalty for rape in that State (Florida) requires an extra margin of confidence.

The rate of unfounded rape in the departments visited ranged from 1 percent to 25 percent, with most departments having a rate of 10 percent or less. These rates are derived by several means. Some investigators unfound a rape case on the facts and after review only by their immediate superiors. Other departments unfound some cases on this basis, but also present weak or suspicious cases to the district attorney for a determination of whether to prosecute. This relieves investigators of the responsibility for making a decision, and keeps the unfounded rate low; on the other hand, it increases the number of cases that are cleared by means other than arrest.

Other factors are also responsible for the wide range of unfounded rape rates. For example, if a patrol car responds to a location where a rape has allegedly taken place but no one is present, some jurisdictions require the officer to submit a report of an unfounded rape. In other jurisdictions no report is required for such "unfounded radio runs." Cases of victim noncooperation in follow-up investigations are also cleared as unfounded rapes in some departments, while others clear those cases as "closed with no results." One jurisdiction, in which hospitals must report rape cases to the police, unfounds cases in which the victim does not cooperate in the police investigation despite a medical examination with positive results. The rationale for this is that there is no proof of force. Nevertheless, many departments do not unfound these cases, but close them as unresolved.

B. Patrol and Support Services

A major mission of patrol is crime prevention. However, the limited evidence available indicates that patrol is largely incapable of preventing rape, which is primarily an indoor crime without witnesses.[2] As a result, this responsibility has fallen to other police personnel, particularly those in charge of community education and public relations.

The actual function of patrol in rape cases is to respond rapidly and on a 24-hour basis. In all of the departments surveyed, patrol forces responding in rape cases are responsible for (1) assessing the victim's medical needs, (2) determining that a rape has been committed, (3) rapidly transmitting a description of the suspect, (4) preserving the crime scene, and (5) searching the area for the suspect.

Patrol forces assigned the entire preliminary investigation, including evidence collection and preservation, in-depth victim interview, and transportation of the victim to the hospital, are faced with many of the problems sex crimes investigators must handle. The cooperation of the victim is often gained or lost on the basis of police behavior, and the proper collection of physical evidence is essential to a successful investigation. Yet the victim is apt to be reluctant to speak to patrol officers about the offense, and few departments provide patrol with support services to insure the proper collection of evidence.

1. *Changes made in the patrol response.* Two basic approaches have been taken to upgrade

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[2] Chappell and Singer, p. 12; Giancinti and Tjaden, p. 15; and Menachem Amir. *Patterns of Forcible Rape* (Chicago: University of Chicago Press, 1971), p. 145. Chappell and Singer report that 73% of the rapes in New York City took place indoors; 58.2% of the rapes in New York City took place indoors; 58.2% of the rapes in Denver and 55.7% of the rapes in Philadelphia took place in a residence.

patrol treatment of the rape victim and collection of evidence: having female patrol officers interview the victim and training patrol officers in the proper preliminary investigation of a rape case.

a. *Using female officers*. Several departments have instituted a policy that women patrol officers handle the initial investigation of rape.

In a pilot program initiated by the Chicago Police Department in one of its areas, two female officers respond to rapes. These officers, assigned to the Youth Division, are responsible for follow-up investigations of crimes involving the family and missing-person reports; they do not have routine patrol duty. Rape is the only type of case in which these officers take preliminary reports. This experiment was initiated upon the assumption that speaking to a woman about the details of a sexual assault would be less traumatizing and embarrassing for a victim than speaking to a man. It was believed, in addition, that a female patrol officer can elicit more sensitive information from the victim so that male sex crimes investigators will need fewer details from the victim during the follow-up investigation. These female officers are also available to assist the victim in the follow-up stages of investigation and prosecution.

The sex crimes investigators claim that fewer victims have refused to cooperate with them since female officers have been conducting the preliminary investigations. The policewomen, however, are less satisfied with the program. They claim few victims prefer speaking to females or need their assistance in the follow-up investigation. Furthermore, since rape cases take priority over their own investigative work, they are frequently taken off other cases to respond to rape reports. Although they find this disruptive, they expect such use of female officers in rape cases to become citywide in the near future.

Similarly, the Los Angeles Sheriff's Department dispatches a female patrol deputy to the scene of a rape to obtain suspect information, interview the victim, and submit the offense report. Male deputies may conduct crime scene searches, but they do not interview the rape victim.

Other departments do not routinely dispatch female officers to the scene of rape, but will comply with a victim's request to speak to a female officer. This policy allows for courtesy to the victim, but does not disrupt the patrol routine.

b. *Providing special training*. Several police departments have instituted special recruit and in-service training on the proper methods of conducting a preliminary investigation in rape cases.

The Training Division of the Minneapolis Police Department has developed a videotape showing both incorrect and correct patrol response at the scene of the rape and during the hospital examination. Each segment is followed by classroom discussion about these procedures. The Los Angeles Training Division's videotape on the preliminary investigation of rape is coordinated with classroom lectures and workbooks. No examples of poor procedure are shown because the trainers believe that officers will remember these procedures as well as the better ones. The Los Angeles film has the additional benefit of requiring the trainee to submit an offense report on the case shown.

The St. Louis sex crimes investigators use videotapes for training at roll call. Segments on exceptional cases and preferred procedures are shown to patrol officers at regular intervals. At the time of the survey, the New York Sex Crimes Analysis Unit and Police Academy were developing a new training film for recruits.

In-service sensitivity training for the handling of rape cases is being run by the Seattle Police Department. St. Paul provides similar training for patrol officers by holding a series of multidisciplinary seminars with lectures by a physician, emergency room nurse, and a rape victim. Chicago policewomen each have had some classroom instruction in rape investigation and have worked with an experienced officer from the pilot project Youth Division in preparation for the citywide expansion of Chicago's program assigning female officers to respond to rape calls.

These training programs stress the necessity for careful treatment of the victim and teach proper evidentiary procedures. Rather than separating the two functions, these films and programs have been structured to show the essential interrelationship of patrol's crime control and service functions in rape investigations.

2. *Relationship of patrol to police support services.* Support units (i.e., mobile crime laboratories, tactical squads, and identification units) can help patrol officers collect evidence, search the crime scene, and apprehend offenders. However, it was found that where departments rely solely on patrol for preliminary rape investigations few, if any, support services are supplied. When sex crimes investigators are brought into the case immediately, other support services are also utilized.

Tucson, for example, has a canine squad, helicopter surveillance, and an identification unit for use when a rape has been reported immediately. The District of Columbia tactical squad and the Ft. Lauderdale canine unit are two more examples of patrol support. All these departments dispatch sex crimes investigators to the scene of a rape on a 24-hour basis and also provide these extra services.

Most departments relying on patrol for preliminary investigation do not provide technical support services in routine rape cases. Departments generally report that this is due to budget limitations and the resulting lack of sufficient personnel or resources. However, an equally important consideration is the failure to give sufficient priority to rape investigations. Several departments have crime laboratories and other support units but use these resources only for homicides and homicide rapes, not for most rape cases.

C. Victim Services

Several police departments have taken on additional responsibilities for the victims of violent crime. While there has traditionally been a split of jurisdiction between the patrol service function and the crime prevention and control function, this distinction is becoming blurred by the acquisition of, or cooperation with, civilian personnel to assist victims of crime. Using civilian personnel provides the victim with additional support and also increases the probability of her cooperating in the investigatory and prosecutorial processes.

A number of programs developed to assist rape victims use both police staff and professional consultants.

In Tucson, investigators have been working with a public health nurse and a county mental health consultant for the past three years. They have established a program of follow-up medical care, consultation with a social worker, and referrals to other agencies. Investigators notify the victim of these services and inform her that she may accept or refuse them. The public health nurse consults with victims for as long as they need her, and she assists investigators in cases where the victim's cooperation is problematic.

In the District of Columbia, the visting public health nurse obtains rape reports from police files and contacts the victim by phone or mail at her residence to see if she will accept assistance. Although the victim is not given an option of the original contact, its confidentiality is generally assured because no information regarding the nature of this contact is given to anyone else at the victim's home.

Several social services are made available by other departments. Victims and their relatives may be referred to a chaplain, psychiatrist, or a social worker, on request.

In Ft. Lauderdale, two civilians (victim advocates) working for the department under a Federal grant, offer a wide variety of referrals to community agencies but do not provide direct services to the victim. This project is unique in that the victim advocates may be called to the scene of a crime on a 24-hour basis when immediate intervention is necessary. It is also unique because a research component is built into the project. Both the type of victim needing assistance and the type of assistance needed are being assessed by the advocates so that adequate resources can be developed to handle victims' problems.

Several departments have acquired lists of community resources for victim referrals. Where there is a victim compensation program, it tends to receive the most referrals.

Although police have begun to look outside their departments for sources of victim assistance, few departments have used resources within the department to any extent.

For example, many departments have a police psychologist or a consultant psychologist who interviews recruits and helps officers with their problems. Some have psychologists who assist in developing training programs, especially those dealing with sensitive treatment of rape victims.

Although some departments consult with psychologists on special cases, they do so for the officer's benefit rather than the victim's. Few, if any, employ psychologists to counsel victims.

A second resource available for victim assistance has been overlooked by virtually all departments—the police reservist. The only exception is the use by several Minnesota municipalities of female police reserves to augment the limited number of female officers available to respond to rape calls. Reservists' functions could be expanded to include a variety of services for rape victims. These are discussed in the guidelines section.

D. Information Systems

Report writing, record keeping, inter- and intradepartmental exchange of information, crime analysis, and research greatly influence every department's effectiveness in handling rape cases. Accurate, useful information is needed for investigation of individual cases, and baseline data are needed for the formation and evaluation of policies and procedures.

1. *Reporting systems.* Most departments have difficulty obtaining accurate and complete offense reports from patrol officers. Yet this information is especially important to rape investigators who are not called to the scene of the rape. It is also needed for modus operandi information that may be essential in identifying the assailant. Further, factual reporting, rather than patrol reliefs or suspecions, is essential to protect the victim from courtroom attacks on her credibility.

There are various methods of improving report writing. For example, a checklist can help to ensure that an offense report includes offender and victim characteristics, remind the patrol officer or investigator of the information needed, arrange that information so it can be easily computerized.

Many departments have increased their emphasis on report writing in recruit academies. Also, most departments insist on supervisory review of patrol reports in addition to investigator review. Others coordinate with their communications divisions to check that reports are received, that they are complete, and that the charges are accurate according to the narrative.

Although many departments check on the accuracy of offense reports, an unknown number of victims of rape and other crimes do not report the offense to the police. With the exception of the NYCPD's Sex Crimes Analysis Unit's program to encourage victims to call a special telephone number for support and assistance, departments are not attempting to seek out these cases. Internal departmental pressure to reduce reported crime rates, plus pressure from the media and community alarmed about high crime rates, appear to be largely responsible for the reluctance to do so.

Some crime victims report the offense only to some other agency (hospital, clinic, rape crisis center, etc.), and these reports are largely hidden from the police. An increasing number of departments are accepting "third party" or anonymous reports—information given by the victim or another person about the offense without revealing the victim's name. This information is sometimes accepted by sex crimes investigators to add to their modus operandi files, but these reports never become part of official statistics. In a few jurisdictions the anonymous report has been accepted as proof of a prompt complaint to the police when the victim delays her official report. Sex crimes units that accept anonymous reports also use them as supportive documentation in requests for additional funds and personnel for their units.

2. *Crime analysis.* The analysis of crime patterns has important implications for rape investigators. If, as many investigators believe, rape is often a crime of recidivist offenders who do not significantly vary their styles of attack, the cataloging of known and suspected offenders is critical for identification. The isolation of patterns of rapes also has implications for field operations. Although most departments rarely use stakeouts and decoys in rape cases, those that do report such tactics have been successful. To make them effective, however, the time, location, and other variables useful in predicting subsequent attacks must be known to the police. Further, temporary shifting of extra patrol officers into a neighborhood may be warranted if the area experiences a series of rapes.

The analysis of patterns of rape depends largely on modus operandi (MO) files containing information on the rapist's description, method of attack, and other variables. Yet, not all departments contacted during this survey even have such files. Moreover, the quality of files in departments that do maintain them varies greatly. Most departments lack technical skills and equipment to maintain extensive, easily used files. In addition, the utility of MO systems in many departments is hindered by the low priority given to the analysis of rape cases.

Even in departments that have established a specialized sex crimes unit or combined violent crimes squad, analysis of rape cases has been given little attention. Several units have no MO file, while others have manual alphabetical or chronological files. Because they are not cross-indexed, investigators must either search the entire file or, more typically, rely on their memory of offenders with relevant MO's if the victim cannot identify her assailant in mug shot files.

Some departments have developed systematic cataloging systems. For example, the Chicago Police Department maintains review analysts who coordinate with sex crimes investigators in each area of the city. The analysts review crime reports, plot the occurrence of rapes on pin maps, and analyze MO cards prepared by investigators on every arrested suspect. If a pattern emerges, or if an investigator requests a check, that information is compiled manually and distributed to district areas.

Other systems include both suspected and arrested offenders in their files. Computerized MO systems are being developed that will process lists of possible suspects in different types of cases.

The NYCPD expects to adopt the Miracode System of document retrieval adapted for police by the Eastman Kodak Corporation.[3] Data files comprising physical characteristics and offense type variables, a single fingerprint, and a photograph of each offender will be stored in the system. The computer operator, working from a remote terminal, will feed case information into the system, and a list of possible suspects then will be supplied to the operator. As the information fed into the system becomes more detailed, individual case files of possible suspects will be displayed on the operator's video screen.

This type of identification technique promises major savings of both the victim's and investigator's time, while increasing the probability of identifying an offender. Such systems are expected to have the most favorable benefit-cost ratio in populous metropolitan areas with both a large offender group and extensive territory.

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[3] See generally *Prescriptive Package: Police Crime Analysis Unit Handbook* (Washington, D.C.: U.S. Government Printing Office, 1973).

3. *Research.* In theory, applied research on rape could produce substantial operational benefits to police departments. However, even in departments with recently established sex crimes units, little applied research is being conducted or encouraged by outside researchers.

A few exceptions were found. The Los Angeles sex crimes detail surveyed rape victims to learn their reactions to police treatment. Particular emphasis was given to determining the relative sensitivity and competency of male and female investigators. The Police Foundation is currently funding a project in the NYCPD in which researchers are sitting in on interviews and interviewing victims. The purpose is to observe police interviewing techniques and to assess the appropriateness of different interview styles with sex crimes victims.

The Ft. Lauderdale victim advocates, who work closely with the police and refer victims in need to appropriate agencies, are conducting some research as part of their project. They are assessing the kinds of needs associated with different classes of victims. Although the advocates do not deal solely with rape, rape victims are included in the study. Similarly, the Sacramento police, funded by a Police Foundation grant, have developed basic information on the needs of crime victims, including those who had been sexually assaulted.

Research on many issues of importance to law enforcement is needed. Some of the issues include (1) the relative success and expense of using specialized sex crimes investigators, generalist detectives, or patrol officers for rape investigations; (2) the utility of specialized sex crimes squads operating on a part-time basis compared with that of combined crimes against the person units working on a 24-hour basis; (3) whether, and in what manner, female investigators are more capable than males in handling rape cases; and (4) what qualities are important for sex crimes investigators.

4. *Departmental dissemination of information.* Most departments use their standard means of communication for disseminating rape case information. Radio calls, written memoranda and bulletins, and information obtained at roll call are the ways patrol officers are notified of daily rape reports.

These procedures for issuing initial crime report information have been much more effective than the means used for informing patrol officers of the outcome of rape cases. As investigator workloads have increased, most departments have relaxed requirements that investigators feed case resolutions back to patrol. Shared responsibility for the flow of information is the claimed policy of most departments, but this often means that patrol officers are responsible for contacting investigators about the final disposition of their cases.

Some sex crimes units, however, require investigators to routinely feed back written information on case outcome to patrol officers. This practice is considered important both as a training device and as a means of enabling patrol supervisors to assess the quality of patrol performance. A formal means of feedback enhances patrol and investigator relationships that are essential to effective exchange of information.

Some departments also assign liaison officers to patrol and investigative units to gather and coordinate information. Liaison officers circulate periodic bulletins. They also help resolve disputes between patrol and investigative units. In addition, they have pointed out areas in which patrols need more training and have assisted in the development of instructional programs. In Tucson, for example, the liaison officer has collaborated with the sex crimes unit to produce videotapes on sex offenses for roll call training of patrol and to provide extensive information to patrol on selected cases.

In addition to encouraging investigators to be more responsible to patrol, some departments have attempted to increase the flow of information from patrol to investigative units. Several departments require patrol to submit reports to investigators on the follow-up of cases or on other street activity unknown to investigators. In some cities, patrol officers must submit "field interview" cards to investigators. These cards contain information about persons questioned, but not arrested, by patrol officers. Investigators check them for possible suspects by matching the description of the person stopped, the time and location of the stop, and the crimes committed in that area at that time. It is reported that this information is particularly useful in cases in which good descriptions of the rapist are available but the victim's report has been delayed.

However, much of the communication between investigators in specialized squads is informal. Many departments cluster their investigative units in close proximity to facilitate information exchange among them. Other more systematized forums for interaction have been devised by most departments, but few relate specifically to rape.

Most detective bureaus have monthly supervisory meetings in which information is exchanged and later disseminated to other investigators. Some hold daily meetings to exchange information. Investigators in other departments meet only as needed to collaborate in specific cases. Rape investigations that entail the use of decoys or the setting up of surveillance or stake-outs, or involve other felonies, are the cases in which sex crimes investigators most often collaborate with other specialists.

In departments large enough to have several regional sex crimes units, sex crimes analysts help to coordinate the units' activities. The analysts disseminate patterns of rape, alert the various divisions to recently arrested suspects, and develop guidelines to insure uniform policies and procedures.

E. Relationships with Other Agencies and the Public

There is an increasing awareness in many police departments that a coordinated, comprehensive approach is needed in handling rape cases. The need for accurate medical evidence, victim cooperation, and a good working relationship with the prosecutor, spurs coordination among hospitals, prosecutors' offices, police departments, and citizens' groups. Outside pressures from the media, rape crisis centers, and other community groups that stress the need for victim care and emphasize the low conviction rate of rapists are also partly responsible for police recognition of the need to coordinate with other agencies in rape investigations.

1. *Coordinating with other agencies.* In response to these internal and external pressures, a number of departments have either initiated contact with other agencies or cooperated with agencies that have contacted them.

The Sex Crimes Analysis Unit in New York, for example, has worked with city hospitals to improve medical treatment of the rape victim and to revise evidentiary forms. The unit has cooperated with local community action groups, and the unit's supervisor serves on the Mayor's Task Force on Rape.

Similarly, a member of the Homicide Sex Unit of the St. Paul Police Department, acting as the police liaison to the hospital, has been instrumental in changing hospital protocol for the rape victim and in planning revisions in the hospital's evidence form. A number of hospital and social service professionals and a sex crimes investigator in St. Paul have created a multiagency approach to coordinate victim services and train agency personnel. The Sex Offense Branch of the Metropolitan Police Department in the District of Columbia has collaborated with the D.C. General Hospital to improve procedures for the treatment of victims and collection of evidence. In addition, the services of a Public Health Department nurse are available to the unit for follow-up counseling of victims. By participating in these efforts, the police in these departments have a voice in procedures that directly affect their efforts and can express preferences for other agency procedures.

In Tuson, a public health nurse, a county medical health consultant, an assistant county attorney (who handles the majority of rape cases), and representatives from the Pima County Sheriff's Department and the Southern Tucson Police Department form a Sex Crimes Squad that works with the sex crimes investigators. The group meets once a month to exchange ideas and information, and the sex crimes investigators are in touch with the public health nurse even more frequently.

In other sex crimes units, contacts between investigators and personnel from other agencies tend to occur as needed rather than in regular meetings.

2. *Relationship with the public.* Sex crimes investigator contacts with the public are usually aimed at preventing crime and providing information about the sex offense unit. Most newly created or reorganized squads have tried to draw attention to themselves in the expectation that more victims will report rapes if they know the police have special personnel or procedures to investigate rape cases.

The New York City Police Department's Sex Crimes Analysis Unit has widely advertised the Rape Report Line in both English and Spanish, and has made numerous public and TV appearances to inform the public of its new services. Other newly created sex crimes units have also publicized their special procedures in the mass media.

Most departments provide speakers to community groups on request, and the recently established sex offense units have been especially active in public speaking. Their purpose has been to prevent rape by alerting women to potentially dangerous situations and to stress the importance of reporting rape to the police. Several departments have written pamphlets and developed films on rape prevention.

3. *Fragmentation of cooperative efforts.* As previously indicated, in a few cities police, hospitals, and other agencies and groups have developed cooperative arrangements to facilitate the control and prevention of rape and to enhance the sensitivity with which victims are treated. However, in none of these cities which we visited are these arrangements developed to their fullest potential, nor do they include all of the community's relevant agencies and organizations.

It was beyond the scope of this study to explore the reasons for this state of affairs. It may be noted, nevertheless, that the inability of police and other organizations and groups to work together effectively is harmful both to the institutional self-interests of the agencies and to the victims of rape. Greater initiative by police officials to promote better working relationships and to devise innovative alternatives to the presently fragmented services for victims is sorely needed.

CHAPTER III. SUGGESTED GUIDELINES FOR POLICE

This chapter suggests guidelines for consideration by police departments interested in reexamining their current policies and practices for the control of forcible rape. These guidelines are based largely upon the survey results. They also draw upon the suggestions of police officers and others who combine experience in rape investigations with a humane yet professional concern for the victims of this crime.

The guidelines open with proposals for substantive and organizational changes that could affect the quality of the law enforcement effort. These center around ways to organize a rape investigation unit, training for rape investigators, and quality control methods.

Following these broad suggestions are more detailed guidelines for the actual process of following a rape case from the victim's call through to the arrest of a suspect. Methods for conducting interviews, improving MO files, and obtaining evidence are among the guidelines presented.

In addition, the relationships of police departments with other agencies and with the public, some special needs of rape victims, and research needs are considered.

A. Organizing a Rape Investigation Unit

A special rape investigation unit is not the be-all and end-all of police improvements in dealing with reported rapes. Rather, such a unit is a limited, organizational expression of three policy determinations: rape is one of the most serious violent crimes; its investigation requires a high level of skill, especially in working with the victim; and the application of that skill to the needs both of the victim and of law enforcement should occur as soon after the event as possible. Operationally, that means organizing to make the services of skilled investigators available 24 hours of every day.

The effectiveness of a rape investigation unit depends to a surprisingly high degree on the cooperation and coordination of other units in police departments: on the operator/dispatcher, on the patrol force, the mobile crime lab, the arrest processing staffs, the inspectional services unit, and on other investigative units. However, only the last of these will be considered in conjunction with the rape investigation squad in this section.

1. *Number of special investigators.* One way to assess the number of rape investigators needed to staff a special unit is to take a benchmark figure of cases-per-investigator-per-year, factor in the total number of rape cases that experience shows a department is likely to handle in a year, and then conclude how many full-time rape investigators that volume would require.

Unfortunately, neither the survey nor other sources of information have provided us with a reliable starting point—a useful approximation of the number of cases a good investigator can handle in a year. The number that has been chosen is based on admittedly preliminary evidence: 30 cases a year per investigator.

Thus, assuming that it takes a minimum complement of seven investigators to staff a full-time, round-the-clock rape investigation squad, only those jurisdictions with seven times thirty reported rapes a year (or roughly 200 cases), should contemplate a special unit of this kind.[1]

The second complementary approach is to plot out the incidence of rape by the hours of the day and the time of the year to examine the peak periods of rape calls, so that the unit's staff can be deployed appropriately.

These approaches to planning may help a department develop an ideal model. But practical realities will often intrude: the crime rate is too low to warrant a full-time squad, or for other reasons, an investigation unit devoted solely to rape cases seems inappropriate. At this stage, other planning devices should be used to think through the configuration of the unit—devices, such as experience and common sense.

2. *The homicide squad as prototype.* For obvious reasons, most departments develop special investigators in homicide. That model should be the rape prototype for three reasons.

- Rape is perceived as the most serious class of violent crimes with a surviving victim.
- The police response and investigation in rape cases require just as much skill and as many resources as do homicide cases. (Actually, some rapes may present the police with difficult investigations if they involve such problems as delayed or unfounded reports. Most departments now give rape a lower priority than homicide and provide investigators fewer resources and support units.)
- Keeping the homicide model in mind when planning a rape unit will help planners avoid setting up a "showcase" section geared more to public relations than to improved law enforcement.

For these reasons, departments contemplating a rape-plus-other-crimes unit should first consider making the combination with the crime of homicide. This pairs the most similar crimes against the person. Departments have traditionally selected only officers of exceptional competence to investigate homicide, and such competence should also be applied to rape cases. Should such a combined unit be formed, however, supervisors should be wary of letting homicide cases drain investigators and resources from rape investigations.

3. *Other combinations.* Departments often add sex crimes, which are related to rape in behavioral terms (nonconsensual sodomy, child molestation, etc.) into the jurisdiction of the rape squad. Such units also sometimes pick up rarely occurring felonies, because the department has no appropriate place to put them. While this appears organizationally harmless, it is not recommended that the rape-investigation unit also have jurisdiction over sex crimes between consenting adult parties, such as prostitution. Such "vice" or "morals" cases present entirely different problems for law enforcement than do forcible sexual assault, and they require entirely different strategies and skills of the specialized units that deal with them.

Other combinations may be attempted, such as assigning certain aggravated assaults to the unit. However, investigators in the unit should not become so overwhelmed with other kinds of cases that they rarely work on rape cases and develop no special skills in handling them. When this occurs, no amount of special training in the handling of rape cases will make genuine specialists of these investigators.

4. *Backup support units.* Crime is no respecter of sensible allocations of police manpower. There will be times when a rape call comes in and there is no rape investigator available to respond to it.

There are two separate systems for meeting that contingency, plus a third one that mixes the two.

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[1] See Roy C. McLaren, *Allocation and Distribution of Police Patrol Manpower* (Gaithersburg, Maryland: IACP, 1966). Although the title of this study indicates that it applies only to patrol, according to correspondence with the IACP, its principles are applicable to other squads.

First, smaller departments may establish a system of putting off-duty rape investigators in an on-call status, preferably on a rotating basis, by using electronic paging devices. This technique has effectively transformed some units that appear to be daytime-only squads into round-the-clock units. It does, however, involve administrative and budgetary problems that must be overcome. Officers in an on-call status in some departments, for example, must be paid for working overtime, unions often object to the extra work, and civil service regulations may have to be amended.

Alternatively, some departments designate other investigators (generalist detectives, for example) as the fall-back staff whenever rape specialists are unavailable. While this is a less satisfactory solution, it has inherent advantages over the other common expedient, which is to delegate the on-scene investigation to patrol officers.

One city (Ft. Lauderdale) has a mixed system: at least one supervisor of the rape specialists is available at all times and assesses each rape report after it comes into the dispatcher. On the basis of the assessment, he decides whether to call an off-duty investigator or to assign the on-scene investigation to another officer who is not a specialist in rape cases. This is a good example of how scarce resources can be creatively stretched to cover emergencies.

In any case, whenever nonspecialists are dispatched to a rape scene in lieu of the special investigators, they should scale down the scope of the victim interview, remembering that another investigator will later interview her in depth. The appended Special Order used in St. Louis (Appendix I-D) provides useful guidelines in this respect.

B. Recruitment and Selection

Since all departments have established methods of responding to rape, it is only realistic to describe any organizational change as evolutionary. Some procedures and some investigators will most certainly remain the same.

But, it is important to stress that changing the organizational form is not enough—one should expect a change in the personnel assigned to rape cases (in addition to an increased number of such investigators) and an effective effort to retool the skills and procedures applied in such cases. In addition, administrators should take steps to make rape investigation into a job that is considered prestigious—one officers will logically aspire to as part of their upward career path.

1. *The plan*. The considerations discussed in the previous section should be developed into a concrete plan that describes the location of the new unit in the department's structure, the number of positions assigned to it, and the procedures the unit will follow in handling rape cases.

2. *Recruiting*. Recruitment should aim to get officers with the rank and experience to be eligible for the level of a senior investigator. This may include staff already at that level (e.g., homicide investigators) or eligible to advance to that level (e.g., crimes against persons investigators).

While recruitment of well qualified officers is to be of paramount concern, it also is well to keep in mind the reverse side of this problem: investigators who originally may have been highly competent can become emotionally drained or even callous over time. The sensitivity that some individual investigators once possessed may become dulled through too frequent exposure to the stress inherent in rape investigations. These persons should be rotated in rape assignments, since retraining is unlikely to be effective.

The investigation of rape cases requires the capacity for creative detective work. Departments typically have established methods for measuring these intellectual attributes in selecting homicide detectives; the same standards should apply here.

However, in rape cases, there is an extra, essential ingredient that must be considered: the temperament to be able to effectively interview a victim soon after what may be the most traumatic event of her life. Clearly, officers who feel strong antipathy towards victims of rape, who are unlikely to have community sympathy—prostitutes, for example—are inappropriate candidates. But the needed temperament goes beyond the absence of a strong class of sexual biases; it also means an ability to be a calm and calming interviewer of distraught victims.

Departments should carefully examine each candidate's work performance, especially in situations of a comparable, traumatic nature. With the final candidates, this may even involve conducting "audit trails" on selected cases (see Quality Control: Inspectional Services, page 29). It may also involve interviews with the police psychologist.

C. Training and Retraining Rape Investigators

However large the rape unit, the likelihood is that few new members will be trained at any one time—perhaps only one or two. Therefore, the following strategy aims to have existing investigators, working with a training officer or training consultant, develop a system of on-the-job training for new members. This exercise will serve to retrain existing staff, and it will provide insights for continuing in-service training. On the other hand, should the department be in the position to retrain its rape investigators en masse, it may be preferable to assign the development and implementation of such training to its police academy staff.

1. *Developing a collection of case materials.* Some departments have collected all the papers associated with selected rape cases: investigators' notes, statements, lab reports, court papers, and transcripts. Transcripts of the rape call, the dispatchers' instructions, instructions of the patrol supervisor, and the investigator radio broadcast can be added to the collection. One or two such records of a rape case are an excellent introduction to the realities of rape investigations.

2. *Listening to sounds of a rape investigation.* The actual tapes of rape calls, as well as those of the patrol supervisor, patrol officers, and the investigator using the police radio, plus a recorded interview with a victim, will give an added dimension to the study of what is involved in a rape case. Such tape recordings should be used not only to orient new investigators to work on the rape unit, but also as discussion material for upgrading the skills of existing staff, including investigators, operator/dispatchers, and patrol supervisors.

It is prudent in preparing such tapes to edit out references to the victim's and the defendent's names, or substitute fictitious names.

3. *Seeing and experiencing a rape investigation.* Departments may develop or borrow films or videotapes relating to rape investigations; such visual materials have been used in some departments. When skillfully done, they have even more impact than audio tapes.

The most advanced method of introducing practitioners to a new job is to have them actually practice it in an almost-real setting. However, these "simulation" or "role playing" exercises may require specially trained actors and trainers as well as professionally prepared scripts. If a department has access to this technology, role playing is an excellent method of teaching investigators how to handle the more difficult aspects of taking command of a rape scene and interviewing the victim.

4. *Other training methods.* All departments should review and update their police academy training courses regarding the craft and technical skills needed for detective work, and relate them to rape.

Additional ideas on training and retraining rape investigators may be drawn from the appended training materials.

Moreover, because of the critical importance of patrol in the police response to a rape call, departments should insure that new recruits are given a thorough grounding in patrol responsibilities in rape cases. Similarly, whenever the need for inservice, roll-call training of patrol officers arises, such training should be provided.

5. *Other agencies and organizations*. Departments should be prepared to assign, upon request, experienced investigators or other appropriate personnel to assist hospitals, prosecutor's offices, rape crisis centers, and similar organizations in training their staffs or volunteer workers. Such assignments are major opportunities for developing improved working relations with these institutions and groups. An effective presentation by the department's representative, for example, can help to clarify not only what police do, but how and why they follow these procedures. The contraints under which law enforcement officers work may not always be apparent even to some prosecutors, much less physicians, rape crisis center volunteers, and others less familiar with law enforcement.

As important as clearing up factual misconceptions is the need to identify any areas of disagreement. The trainee group may be critical of certain aspects of the department's activities, not because they are misinformed but because they want them changed. While it is likely that the department has received similar criticisms in the past, complaints that surface during training may involve fresh information, new suggestions, or other factors meriting consideration. In this event, the department's representative should relay this input to appropriate officials in the department for review and possible translation into revised policy or procedure.

Departments also should involve representatives of various outside institutions and agencies in their own in-service, recruit, or other training. Former rape victims, physicians and nurses assigned to emergency rooms, and prosecutors who have handled rape cases are among those who, by reason of their special experience or training, are likely to be exceptionally well qualified to supplement a department's training capability.

In addition, however, it may also be useful to seek assistance from mental health centers, rape crisis centers, and feminist organizations that have had experience in counseling or otherwise assisting rape victims. Criminologists, psychiatrists, and psychologists who have studied or treated rapists can contribute to the trainees' understanding of the offender, while defense counsel, judges, and forensic medicine experts will be helpful in their areas of specialization.

Scheduling and other administrative problems grow as the number of representatives from other organizations is increased. These people may be unfamiliar with what each other will be saying, causing some topics to be overdiscussed while others no less important are given only limited or one-sided treatment.

Careful preparation can alleviate many of these difficulties. One approach is for the department's training officer to set up a small committee of himself, an experienced rape investigator, and knowledgeable representatives from one or two outside agencies. These might be the administrator of the community's public hospital, a rape crisis center volunteer, or a member of the prosecutor's staff. In addition, it may be advisable to invite representatives from one or more neighboring police departments, particularly those with a substantial rape problem (i.e., campus police).

This group should review relevant studies, agency policies, films, and other such materials to develop needed background information. Thereafter, it would decide upon the training program's basic goals, the trainee group (patrol, investigators, recruits), and the facilities (stationhouse, academy). Development of the curriculum outline and identification of the persons (within or outside the department) to conduct each portion would follow.

Thereafter, the committee would work to insure that each trainer understands what is expected of him or her and how it interrelates with other segments of the training. The committee would review all films or other materials that the trainers plan to use and suggest alternatives where appropriate. It would work out scheduling to cause as little disruption to routine operation as possible and to avoid inconveniencing the outside trainers. Plans for evaluating the training also would be prepared and an evaluator designated.

Not infrequently a carefully developed training program will lead to a reconsideration and reformulation of existing policies and procedures. The need to create a new rape unit, revise the duties of patrol officers in rape cases, or revamp MO files may become apparent once the deficiencies to be addressed by the training are discovered. It is important that these insights not be ignored but instead documented and forwarded as recommendations to the appropriate official. In many cases it may be essential for a substantial reorganization to take place in conjunction with the training, which then becomes a means of implementing these new policies.

D. Quality Control: Inspectional Services

Many departments have an "Inspectional Services" division functioning as an organizational quality control system. Its procedures in reviewing the rape unit's cases are no different from those it uses for patrol or other investigative units. Yet the public sensitivity attached to rape requires that the Inspectional Services unit monitor the work of the rape squad more closely.

Note that the task of Inspectional Services is not that of an internal inspection division: it is not aimed at serious wrongdoing or corruption. Rather, its mission is to see whether line staff members are adhering to regular departmental policy and procedures, and to recommend corrective action when irregularities are uncovered.

1. *The audit trail.* Inspectional Services officers should conduct "audit trails" of a random sampling of rape cases. An audit trail is a review of all the reports, papers, and steps taken by everyone connected with a case. It always starts with the first report of a crime, then leads the reviewing officer to the responding patrol officer, the investigator, the victim, the lab technician, the prosecutor, and everyone else involved in the case. The reviewing officer seeks to reconstruct exactly what happened, then measure this account against the official reports of the case and written policies and procedures of the department.

Occasionally, this inspection leads the department to take disciplinary action. Normally, however, the reaction to under-par performance is to see how the department's leadership can correct such problems in the future. The aim is to search for system malfunctions, not individual errors, and, thus, the inspection should be seen as a positive, nonthreatening function. Accordingly, the Inspectional Services unit should directly or indirectly help to improve standing and special orders, roll-call training, supervisory skills, and the like—all of which are especially needed in rape investigation units, which have a particularly difficult mandate.

2. *Cases of victim noncooperation.* In addition to its random sample of rape cases, the Inspectional Services staff should run audit trails on every rape case that has been closed because the victim decided not to prosecute. The department's ability to find and correct practices that lead to victim noncooperation will have a major, healthy effect on the proper handling of rape cases. One may expect that a certain number of these "exceptionally cleared" cases will be unavoidable, while others will be precipitated by actions outside the department's direct control. But even discoveries of the latter can lead to improvements in the overall system.

The reviewing officer may have difficulty talking to the victim in these cases. It may help if the officer is not in uniform when interviewing the victim, and if he or she clearly indicates that the purpose of the interview is not to get the victim to change her mind but just to better understand what happened.

E. Women Officers and Civilian Aides

The recent increase in the establishment of special rape investigation units has been paralleled by two other innovations in many police departments: a substantial increase of women performing police work as sworn officers and a significant rise in the use of both male and female civilians as specialized staff in police departments.

Both, of course, are highly relevant to the subject of this report: many new rape investigation units have been staffed with substantial numbers of female officers, while the growing efforts of such units to meet the social service needs of victims have led them to make creative use of untraditional aides to law enforcement—both in and outside of police departments.

This innovative use of personnel is still in an early stage of development. Most departments are composed overwhelmingly of men, with any women serving in such traditional roles as jail matron, juvenile officer, and secretary.

1. *Women patrol officers*. Female officers serving in the patrol division are potentially of help in rape cases. However, not every such officer is likely to want to be assigned to this type of case. All patrolwomen and, indeed, other female officers should be polled to determine whether they would like to serve in this capacity.

Any volunteers should then be given an orientation in the procedures of a rape investigation, what to expect, and what is expected of them. This should stress two points: the emotional problems and needs of the victim, and the law enforcement need for cooperation by the victim.

Whether such an officer called into a rape case should conduct the in-depth interview or even assist the investigator in conducting the interview is questionable. As a general proposition, the assumption should be that no female officer is, by reason of her sex alone, competent to conduct victim interviews, subject to some practical exceptions. Among these are requests by the victim to have the woman officer stay for the interview, or when the investigator sees that the woman is having a clearly salutory effect on the victim. In such cases, the interview should be held jointly.

2. *Recruiting women as rape investigators*. Departments should seek to have women serve on the rape investigation unit, and should develop recruitment plans accordingly, subject, however, to the maintenance of eligibility criteria and skill. On the other hand, it is not advisable to create an all female sex crimes unit or to have only women interview rape victims. Such practices not only build resentment in male investigators, but also increase the likelihood that the unit will become a "female ghetto" (as has happened with juvenile crime units) with lower prestige in the department. Such a development will seriously jeopardize all other efforts by the department to give rape the highest of priorities.

The difficulty with hiring women per se—as some departments have done in assigning women officers without patrol experience to a rape unit—is that it is based upon one or both of two assumptions: that a woman, by virtue of her gender, will intuitively know how to deal with rape victims and conduct rape investigations; or that the practical skills needed for the interviewing and the investigative aspects of the job are either unimportant or are rapidly learnable. Both of these are dubious propositions.

Of all the officers interviewed during the field visits for this report, the one expressing the least sympathy for rape victims as a class was a senior female officer. On the other side of the coin, researchers, such as Bard and Ellison, suggest that an effective and empathetic male investigator can serve as a useful symbolic image to rape victims and help them restore a trusting relationship with men.

These and other such indicators suggest that it is precipitous to recruit women into the rape unit who do not meet the standards suggested earlier.

However, that does not get the department off the hook if no women candidates are thus currently available: if correcting that lack of eligible women requires increasing the number of women in the detective bureau, or even in the patrol ranks, steps should be taken in that direction. In this day and age, there is good reason—and a growing body of supporting evidence—to include women in law enforcement.[2]

3. *Using civilian aides*. Departments have used these kinds of unsworn staff to assist rape victims:

- Victim advocate
- Social workers
- Public health nurse
- Police psychiatrist
- Police-hospital liaison worker
- Police reserve officer

All such workers, whether professional or paraprofessional, hold the promise of getting more social services for crime victims generally and rape victims specifically, either directly or through referral to other agencies. That promise is especially welcome. As discussed in greater detail in the section on citizen action, many rape victims need both short-term and long-term assistance with their crises. Police should facilitate the provision of such assistance on humanitarian grounds alone. But, in addition, police involvement in helping victims cope with the crime and its associated stress is likely to encourage greater cooperation from victims, enabling police to do their job better.

A number of departments have recruited civilian volunteers. However, there is minimal use of reservists and other similar volunteers to serve as victim aides; only a few jurisdictions reported employing such personnel for this purpose. On the other hand, some women reservists have been known to help staff precinct houses over night shifts; this suggests a potential for recruiting volunteers to assist rape victims during the hospital visit, to accompany her to social service agencies and court proceedings, to explain and interpret agency and court procedures, and the like. Moreover, an additional useful function is, under the supervision of the investigators, to keep the victim notified of the status of her case, including notice of a suspect's arrest or release on bond. The reader should consult the guidelines in Section 4—The Response of Citizens' Action Groups for a review of service roles for rape victim counselors.

F. Considerations in Answering the Rape Call

The following recommendations are aimed primarily at identifying and responding to the rape victim's emergency call to the police shortly after the event. While rape is frequently reported by family or friends of victims and is sometimes reported long after the attack, primary attention is directed here at the emergency calls of victims, since these are the most difficult and important for police to handle well; what is meant by "well" is described in subsequent recommendations. Other kinds of reports are discussed afterwards. In the discussion that follows, the term "operator/dispatcher" is used. When the functions normally performed by this person are given to different members of the department's staff, the text indicates which function is being addressed.

1. *The call and the operator/dispatcher*. The police operator or dispatcher's first job in answering a rape call is to determine if it is an emergency situation. Any one of these factors places the call in that category: the victim states that she has serious injuries; she says that the event was recent; or her manner of speech indicates that she is suffering severe emotional distress. Each department should develop operational guidelines or orders to specify precisely the criteria to be used in identifying emergency

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[2] See generally, Deborah Anderson and Peter Block, *Policewomen on Patrol—Final Report* (Washington, D.C.: Police Foundation, 1974) and Brenda E. Washington, *Deployment of Female Police Officers in the United States* (Gaithersburg, Maryland: IACP, 1974).

calls. These guidelines should be disseminated throughout the department.

With every such call, the operator/dispatcher must assume that the victim is in a state of crisis—even if she seems calm and rational. (See Appendix I-B.) Therefore, his or her tone and manner must be calm and supportive of the victim throughout the call. The next steps are recommended as being appropriate to a crisis of this magnitude.

The operator/dispatcher's next responsibility is to get the victim's name and present location, then to dispatch patrol officers, and if appropriate, an ambulance, to that location, indicating it is an emergency rape call. That police call should trigger an alert on the part of listening officers—the consequences of which are discussed later.

The operator/dispatcher next seeks to get three other pieces of information from the victim: (1) the location of the attack, (2) the identity or description of her attacker, and (3) his means of escape. Whatever information he or she can get in a brief time is then transmitted to the responding cars, and he/she posts a preliminary "lookout" (radio braodcast) for all the other cars.

Next, the operator/dispatcher calls the supervisor of the patrol officers responding to the call (if the supervisor has not already heard the call and called in). A similar call is also made to the rape investigators' unit and to the mobile crime laboratory.

In the departments where the operator/dispatcher is a police officer, he or she should return to the victim and if possible stay on the line with her until the first patrol officer arrives if the victim is alone or wants to stay on the line. This is designed first and foremost to provide comfort to the victim. Too often it has happened that even calm victims slip into a state of terror after the police operator hangs up and they are left alone.

If, in this process, the operator/dispatcher can get a better description of the suspect from the victim—short of intrusively probing—all the better. If the victim's physical or emotional state prohibits information gathering, the operator/dispatcher can explain what the department is now doing, who is coming to her, and so on, to voice a sense of compassion and responsiveness to a woman who may be hysterical and who almost certainly is extremely distressed. One essential message the operator/dispatcher must transmit is that the victim should not destroy any evidence—not take a bath, destroy her clothing, or touch articles or furniture the rapist may have touched, and so on.

It must be recognized that police operators and dispatchers receive an endless flow of calls of distress—crank calls and the rest—which can naturally induce callousness. Thus, to affect the policy underlying this section, a program of training and retraining for this staff is necessary.

2. *Variants on these procedures*. Even in well-staffed departments, there may be times when an operator/dispatcher cannot stay on the line with a rape victim because of the volume of incoming calls. In addition, an increasing number of departments are hiring civilians for operator/dispatcher positions. They may be ill-equipped to deal with distressed victims. Where either of these situations exist, the preferred alternative to continuing to talk with the victim is to transfer the call to another officer, preferably a rape investigator, but at least the most sympathetic officer available. A "transfer line" for victims of all crimes who are alone, distressed, and in need of support should be created and staffed with police personnel in any communication division of a department that does not have investigators available on a 24-hour basis. Male and female officers who will be receiving these calls should be trained to minimize the disruption to the victim of talking to a second officer and to accustom the officer to taking on this type of assignment on the spur of the moment. If, however, such calls cannot be transferred to another officer, the operator/dispatcher should suggest to the victim who is alone that she call a friend or relative; he or she might even volunteer to place that call.

Not all rape reports originate with an emergency call: some come in later or by way of a third party, such as a friend or relative, or are walk-in complaints.

However received, any report of a rape that occurred recently should be treated as a high priority case. The dispatcher is alerted and follows all the emergency procedures enumerated above because the victim may still be in a state of serious distress, the evidence may still be salvageable, and the offender may still be apprehended quickly.

In fact, even the delayed report, of say, several days duration deserves special handling. Instead of patrol, the rape investigators are paged, but promptly, because there is still a chance that the evidence is sufficient to make a prosecutable case. Departmental policy regarding the criteria of a delayed report and required procedure should be established and disseminated to the operator/dispatcher, patrol officers, and investigators to avoid mishandling the report.

Most of the other guidelines proceed from the principles already set out. For example, in the case of an emergency call from a third party, the operator/dispatcher should elicit all the information relevant to the crime and should instruct the third person on the importance of his or her supportive role and of the need to preserve the evidence until the patrol arrives.

In the more delayed cases, and in all walk-in cases, any officer first having contact with the victim or an intermediary should direct that person to the rape investigation unit, after determining that a rape has been committed. There should be no attempt to interview the complainant since that would be an unnecessary repetition of what she will have to do later.

Finally, the occasional anonymous report should be taken, and the caller should be encouraged to talk to a rape investigator—it is helpful for law enforcement to know about every attack. Because anonymous reports cannot be investigated, it is more appropriate for departments with a crime analysis unit to have analysts receive this information and include it in reports to investigators. This aggregate information will be more useful to the investigative unit than the individual calls. It will have the secondary benefit of providing proof of the need for more resources and personnel in budgetary requests.

G. Patrol Responsibility for the Victim, the Crime Scene, and the Search for the Perpetrator

Although a good public awareness program, diligent patrol, and high saturation patrol in high crime areas may be helpful preventive measures, the bulk of the police effort is reactive rather than proactive. The best opportunity to apprehend rapists is soon after the emergency call—thereafter the apprehension rate drops off precipitously, unless the victim knows her assailant.[3] The importance, then, of the patrol reaction to an emergency call (just after the crime) and to a high priority call (the crime occurred within the past few hours) is critical.

The patrol force has five responsibilities when an emergency or high priority rape call is broadcast:

- Respond immediately to the victim (and to the crime scene, if at a different location).
- Give attention to the victim's medical needs.
- Establish a rapid, thorough lookout and search.
- Preserve the crime scene *and* the most crucial source of evidence—the victim.
- Accomplish all the above in the most organized and efficient manner possible.

What is recommended below is very much a major undertaking for every such rape call. This is the keystone to treating rape as a crime of the first priority.

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[3] President's Commission on Law Enforcement and Administration of Justice, (*The Challenge of Crime in a Free Society* (Washington, D.C.: U.S. Government Printing Office, 1967): 248.

1. *Reacting to the dispatcher's call.* The car or cars dispatched should get to the victim as fast as possible. Any other car that overhears the broadcast and is close to the victim's location should so notify the dispatcher and get to her as soon as possible. All other available cars should proceed to main thoroughfares in their sectors—that is, to likely escape routes—and wait for a lookout, an improved lookout, or instruction about the search.

This is a form of patrol mobilization in response to a police emergency.

2. *The first responsibility of the first officer to the victim.* This responsibility is, as always, to assess the victim's medical condition and, if needed and consented to by the victim, to call an ambulance if one is not on the way. Alternatively, in emergencies, the officer is to take the victim to the hospital.

3. *An improved lookout.* If the victim is able to talk, the responding officer should get a preliminary, or an improved, lookout, including such information as the assailant's identity and/or description, the approximate lapse of time since the crime, the place of the crime, the assailant's escape route, method of transportation, etc. At this point, however, the officer must sacrifice thoroughness for speed. If the officer cannot get information gently and quickly, it is not desirable to pressure the victim.

If the officer does get a lookout, it should be called or radioed in to the dispatcher immediately. Writing up the report can wait. (A two-officer patrol is a help in this situation.)

4. *The patrol interview of the victim.* The responding officer has a responsibility to interview the victim and write up a report of the crime. The interview must be as brief as possible in order to meet the minimum requirements of the incident report. It should not cover any details of the sexual aspects of the crime except as they relate to evidence that must be preserved and to establish what crime was committed. There are several reasons for this: the victim will be interviewed in depth by an investigator; any such interview can be extremely distressing to the victim; the investigator, and not the patrol officer, is skilled in this delicate task; and, most important, any harm caused by overzealous questioning of the victim at this point will be likely to affect the case as much as the victim by creating negative attitudes in the victim which will reduce her willingness to cooperate.

The patrol officer should also be guided by the same precepts of tact and empathy that are recommended for the patrol supervisor.

5. *The patrol supervisor: task one.* A patrol supervisor has been dispatched and should get to the victim as soon as possible to evaluate the elements of the case—certainly in time to review the officer's performance in taking the victim's brief, initial statement. When a supervisor is able to arrive at the scene early in the investigation, it may be appropriate to supervise inexperienced officers' taking of victim statements.

But the supervisor's first tasks are to preserve the crime scene and reduce anxiety in the victim so that both will be in the best condition possible for the investigators. (Note that for purposes of discussion, it is assumed that the victim is actually at or near the crime scene, or that she can be easily returned to the crime scene.)

Operationally, that means the supervisor first clears out all but one or two police officers from the scene and away from the victim. The supervisor also posts an officer to protect the scene; checks with the responding officer and the victim to see if she has an updated, improved description; makes certain that the victim is comfortable and not in the room where the offense occurred; and insures that the report-taking is brief and discreet. The supervisor, in short, takes charge as quickly and calmly as possible, since he or she must move rapidly to the next assignment.

6. *The command post: task two.* The supervisor leaves, taking all extra officers away from the scene, and establishes a command post to conduct the search if police have a useful description of the suspect. If the rape has been committed in or near the victim's home, the

command post should be set up at a remote location, such as a park, school, or other nonresidential area, to avoid bringing unnecessary attention to the victim and to make her home more accessible to investigators and mobile crime lab personnel. (Here we are assuming that it is shortly after the crime and that patrol has obtained a useful description of the suspect).

There are five functions to be performed at the command post, all premised on having support units available.

- The supervisor routes available patrol cars to cover the roads estimated to be the most likely routes of escape. In the process, he/she communicates his/her best information on the suspect's description, means of escape, vehicle, and so on.
- Other officers are directed to conduct an immediate search of the area for the suspect and to uncover possible witnesses. Officers should be reminded to avoid mentioning to prospective witnesses that a rape has been reported. Such information may become a needless embarrassment to the victim. Instead, it is usually sufficient to ask persons near the scene if they heard or observed anything out of the ordinary and to indicate only that a serious crime is being investigated.
- The supervisor augments this team as needed with members of other support units: tactical squad, scooter patrol, canine patrol, helicopter, etc. This requires an established policy whereby a supervisor in one unit can, in emergencies, get the rapid approval of his/her counterparts in other units to dispatch officers to work temporarily under his/her command. When the supervisor's counterparts are not available, he/she orders by his/her own authority the temporary reassignment of the officers desired. All of these moves to mobilize a search team are coordinated through the dispatcher.
- The supervisor establishes methods to control onlookers and traffic at the crime scene. Congestion at the scene also will be reduced by locating the command post at a distance.
- An officer is detailed to maintain the command post while the supervisor returns to the victim.

All this requires rapid decision-making. It is helpful in mobilizing support units if all the officers involved can communicate through a reserved channel on the police radio.

7. *The victim's welfare: task three.* The supervisor's next task is to return to the victim and to follow-up on the job of "preservation" hurriedly begun earlier.

In addition to the previously described steps to insure the comfort of the victim and the protection of the evidence, the supervisor should sit down with the victim and discuss the following:

First, he or she should inquire if there is someone nearby—a relative or a friend—whom the victim would like to see. If necessary and feasible, an officer should bring such a friend over. Sometimes, when the supervisor is a male, the victim will request that a female officer be there; the supervisor should seek to fulfill that request if a female patrol officer is available. Or, if it appears that the victim is reluctant to speak to a male officer, he should suggest to her that a female patrol officer can be called, if such is the case.

Police departments may find it useful to test the feasibility of calling representatives of rape crisis centers (or other appropriate citizen groups) if (1) a rape crisis center or other group has demonstrated reliable, competent assistance to victims at later stages in the criminal justice process and has cooperated with the department in developing victim support procedures that do not interfere with the investigative process, or if (2) the victim (such as a transient) does not have friends or relatives available, or requests the presence of a volunteer aide.

Next, the supervisor should discreetly monitor the interaction of the victim and anyone she is in contact with, and separate her from anyone—police officer, family member, or friend—who seems to be aggravating her distress.

Throughout this process, the supervisor should be explaining to the victim and the family member or friend police procedure and its rationale, what is being done to apprehend the suspect (where probable cause exists), and the investigative and medical procedures that will follow. Explaining this in detail serves three purposes: it is reassuring to learn of the major effort the police are making in reaction to the reported crime; it turns the victim's attention away from the attack itself and saves her recounting of it for the investigator; and it begins a process of enlisting both the victim and those close to her into cooperating with the police.

Many people undergoing crisis "ventilate" (talk out the experience in a rush of emotion), and the supervisor and other officers should let the victim do this if she is so inclined. This is a useful method that the mind has to try to restore its normal balance. But a caution should be voiced here: the officers should not on their own try to induce this behavior, nor should they use it as a means of probing the victim for information. Note also that victims who are ventilating often break into tears. Crying is a normal response to the crisis situation, and officers should not attempt to stifle it.

Rape victims are often extremely upset—of course. Many are often simply confused, disoriented, or dumbfounded. Others are surprisingly calm, alert, and rational. The supervisor should consider in every case that the woman may be in a state of serious emotional crisis, and respond appropriately and professionally. This means to remain calm and be helpful: absorb all her abuse, provide her continuous comfort, and/or use anyone else on the scene, officer or civilian, who has a supportive effect on her.

All this relates to the time period before the investigator arrives. As soon as the investigator comes on the scene, the supervisor transfers command over to him or her: the investigator is briefed, as many officers as are needed are detailed to him or her, and the supervisor introduces the victim to the investigator. The supervisor's job now is to operate the command post until a suspect is apprehended or the search is called off.

This raises the last likely interaction between the patrol force and the victim—at least in this simplified description of what is usually a somewhat less orderly sequence of events.

8. *One-scene identification of a suspect.* If the lookout is based on a relatively detailed description, and a suspect meeting the description is apprehended shortly after the initial call, it is recommended that the patrol officers bring such a suspect to the command post to have the victim make an on-scene identification. The victim should be brought to the command post for the identification. Although this may be a slight inconvenience for the victim, it is important to keep attention away from her home, and, if the offense did not take place in the victim's home, the offender should not learn the victim's address. Under current Constitutional doctrine, such an apprehension may be made on the reasonable suspicion of a police officer reasonably soon after the criminal event, which some departments translate as being a period of one hour, during which it is permissible to conduct what is, in effect, a one-man lineup.

There are two problems for the victim in this procedure. First, the idea of seeing a suspect shortly after the event is unpleasant. And second, should the suspect actually be her assailant, his presence may be very frightening to her.

The patrol supervisor or investigator should explain to the victim that her identification of her attacker and her clearing of possible suspects whom she cannot identify are essential to their work and the system of justice. The officer in charge should insure that the victim will be able to look at the suspect while remaining in complete safety—she may even be unseen by the suspect.

One technique used at night to meet this latter objective is to place the suspect in a well-lighted place (say, beneath a street light) and have the victim look at him from a place of darkness (such as a darkened room in a nearby building). Another version of the same technique is to have the victim sit in the front, passenger side of a police vehicle with one or, preferably, more witnesses with her and, with the doors locked and the bright headlights on, have the suspect brought in front of the car and then escorted back to another police car after the victim has given her response. No officer should give the victim any indication that this suspect is the rapist. On the contrary, all the officers should be sensitive to the fact that victims are often in a highly suggestible state of mind and may want to please the officers who seem to be hoping for a positive identification from her.

9. *Alternative procedures*. Most of the potential changes in the circumstances described above lead to common-sense changes in procedures. Thus, if the victim requires immediate hospital treatment, the investigator goes there first to meet the victim and talk to her, if possible, and to relieve the patrol officer who has accompanied her. Or if the crime scene is at a different location from where the victim is, the supervisor dispatches an officer to make sure that the crime scene is secured for the investigator and the mobile crime lab. Or, if the supervisor determines that the lookout is too sketchy or the time lapse has been too great to conduct an extensive search, he or she limits the search to the immediate neighborhood of the crime and to the development of possible witnesses.

H. The On-Scene Investigation

The special investigative units for rape cases in several departments work daytime shifts only. Such departments use patrol officers for the initial, on-scene investigations of nighttime rape cases, which constitute the great majority. Wherever this delegation of investigative functions to the patrol division can be avoided, it should be, for the following reasons:

- Investigation is a craft, learned through careful study and the development of skills over repeated use. A comparison of the reports filed by patrol officers and by investigators is sufficient to demonstrate their different competencies. While it is conceivable that many patrol officers could learn the rudiments of rape investigations, that kind of "book-learning" is not adequate, for they would still be missing the necessary repetitive experience. Indeed, the infrequency of rape reports means that many patrol officers may never come into contact with a rape victim.
- On the other hand, orchestrating the patrol force to launch a rapid, methodical search for a rapist shortly after the crime is a more productive and appropriate use of the unique capabilities of patrol.
- Viewing and analyzing the crime scene while it is still fresh is an example of the proper role of an investigator. Precisely the same is true in getting detailed information from the rape victim—done properly, it is one of the most challenging and sensitive responsibilities of law enforcement.
- Even if the victim interview were within the competence of patrol (and, certainly, many patrol supervisors have had extensive experience in investigation), the very process of having a rape victim repeat her story to a series of police officers can only increase the likelihood of her becoming hostile, uncooperative, and emotionally damaged.

Some of those who agree that patrol officers should not perform clearly investigative functions argue that it is not essential to have the investigative process begin right at the scene as soon after the report as possible. In this view, the crime scene can be protected by patrol and checked out by the mobile crime lab or evidence technicians, while the victim can be interviewed briefly by patrol, taken to the hospital, and returned home without the need for a thorough interview. This go-slow approach is urged on two grounds: it is less wrenching for the victim, and, if handled properly, it will induce greater cooperation and encourage a clearer recollection of the event later on. (But, at least some advocates of this approach recommend that the investigator should nonetheless arrive rapidly on the scene to establish contact with the victim as soon as possible.)

The time to establish a supportive, cooperative relationship between the investigator and the victim is as soon after the crime report as possible. And, as most investigators who have worked a homicide detail testify, the time to get the most instructive understanding and "feel" about a crime scene is before it has been raked over by the mobile crime lab.

In addition, this report recommends that, if possible, the investigating officer conduct a complete interview of the victim on the scene and soon after the crime report. However, the investigator must be able to recognize those times when the victim's medical or emotional condition makes such an immediate interview unwise or impossible.

There are two reasons for holding the interview soon after the crime report:

- The rape victim's crisis will sometimes compel her to forget—to "repress"—painful and embarrassing aspects of the crime. Although rapid and insensitive probing of the victim may exacerbate this memory block, it is also true that a lapse of time inescapably washes out many fine details of virtually all our experiences. Having an early interview at least provides an opportunity to avoid this erosion of the victim's memory.
- The victim should not be required to give her account of the attack any more often than necessary for a thorough investigation. By combining the initial preliminary contact with the interview, the investigator eliminates one occasion on which the victim is required to repeat her story.

Two appendixes, the Bard and Ellison article and the International Association of Chiefs of Police "Training Key No. 210: Interviewing the Rape Victim," contain background thinking and recommended procedures that should be considered extensions of this section. The Bard and Ellison/IACP techniques on what it means to treat a rape victim "sensitively" are strongly recommended.

1. *Setting the stage for the interview.* On first meeting the victim at the crime scene, the investigator should assess her medical and emotional condition and take her directly to the hospital, if that is warranted. The interview will probably be rescheduled for the next day in this event.

If an interview is feasible, the investigator should first look to the victim's comfort and privacy. If the attack took place at her home, she may like to have the interview at a neighbor's home, for example. In any case, the setting should be comfortable and private. Since a relative or friend may be with the victim, it is useful to explain to both of them the purpose of the interview and the necessity, for the sake of both the victim and the police, for privacy, but the friend or relative can be asked to stay near by and be prepared to accompany them to the hospital.

In all such interviews, it is important to talk around the subject at first, so that the investigator and victim can get to know each other a little and reduce the tension. Should the investigator want to tape-record the interview, he should ask permission to do so.

Following the example of a few departments, tape-recording the interview is recommended, at least in an experimental fashion and with the knowledge and approval of the victim. This procedure may spare the victim from having to repeat her detailed account of the offense during the follow-up investigation. The problem with using a tape-recorder is that the machine itself is distracting, induces nervousness, and brings an artificiality to the conversation. Visual inhibitors can be reduced by using a small, battery-operated recorder with a built-in microphone, a 90-minute tape, and the moving tape and controls covered up.

Even if a recorder is used, the investigator should take occasional notes on leads and observations about the victim.

Alternatively, if no tape-recorder is used, the investigator should be prepared to take as extensive a set of notes as possible consistent with the need to keep the interview from becoming impersonal. It is preferable, however, for the investigator to start a flow of conversation before taking any notes. This can be facilitated by first focusing on the victim's needs, proceeding to a discussion of how victim and investigator can work together, and, finally, explaining what information is needed. By this point, it should be easier for the victim to talk in more detail, and the investigator should begin to take notes.

2. *Conducting the interview*. On this, see the appended Bard and Ellison article, plus the IACP "Training Key No. 210: Interviewing the Rape Victim," which together are excellent supplements to (but not substitutes for) the extensive literature on effective police interviewing techniques.

An indepth interview at this time is likely to be upsetting to the victim. Although the investigator will want to obtain as much information as possible, it is important to balance the need for facts with the need to alleviate the victim's distress during the interview. Because some of the questions the investigator will have to ask are apt to embarrass her, they should be prefaced with an explanation of why the information is needed. If the interview is put in the context that she is not to blame and that many other women have been victimized by rapists, it may be easier for the victim to talk about the attack. Similarly, if the investigator does not make moral judgments about the nature of the sexual acts that took place nor show shock or disdain, he or she will not stifle the victim's responsiveness. Questions about the rapist's behavior that are open-ended will enable her to speak more freely and not influence her account. If the investigator is able to gear his/her terminology to the level at which the victim is most comfortable, it will make the interview less distressing and, therefore, more informative.

Despite such an approach, some victims may naturally be reluctant to discuss the more intimate details of the crime, and if they cannot be encouraged to do so at this time, they should not be coerced into it. The investigator should not use this reluctance as a means of avoiding subjects he or she finds unpleasant. This simply forces the need for a second interview without necessarily sparing the victim's feelings.

Throughout the interview process, the investigator should attempt, by returning to the subject from time to time, to see if the victim can recollect identifying characteristics of her assailant—his looks, cloths, unusual features, voice, or the words he used, and so on. If nothing new is triggered by these inquiries, turn the discussion elsewhere rather than probe; use the most gentle kind of persistence.

It is always possible that this 30- to 90-minute interview will be interrupted by the news that a suspect has been taken. Should this occur within the reasonable time frame required by the courts, the investigator should take a break in the interview and prepare the victim for the on-scene identification.

3. *Coordinating the collection of evidence at the scene*. Professionals in evidence collection and analysis, such as a mobile crime lab (MCL) team, usually need to know only the basic outline of what is thought to have occurred at a crime scene in order to perform their work. If an MCL is used, the investigator only has to make sure that a reasonably well informed officer (the responding patrol officer, for example) is there to brief the MCL team. Incidentally, if the department has a mobile crime lab, it should be used in every rape case, if needed.

However, if the crime scene is to be checked out by less skilled evidence technicians, the investigator should personally supervise the collection of evidence. This may entail posting an officer to guard the scene until after the investigator returns from the hospital.

4. *Preparing to go to the hospital.* At the conclusion of the interview, the investigator should transport the victim to the hospital. If the victim needs a change of clothes and if it is convenient to stop by her home, the investigator should do so. Otherwise, all rape investigators should make sure that the hospital keeps adequate clothing for rape victims to use when their own clothes are retained for analysis and use as evidence. (Paper dresses and underclothes are inexpensive and convenient.)

5. *Alternative procedures.* Almost all police departments can, and therefore should, establish a division of labor between the patrol officers and a patrol supervisor in rape cases. But, in some departments special rape investigators either do not exist at all or are so few in number that they are often unavailable to respond to rape calls.

Whenever a special rape investigator is unavailable to conduct the on-scene investigation, the dispatcher or other department official with this responsibility should assign, through standard procedures, an investigator or detective from another unit to fill in. Priority-ranking of units by the seriousness of the offenses they investigate, individual experience, and availability of the investigators should be considered in formulating a selection process. However, some departments may wish to delegate this fall-back role to generalist detectives working at the district or precinct level.

When neither specialist nor generalist investigators are available, the patrol supervisor should be assigned the on-scene investigation.

If a nonspecialist fills in for the investigator soon after the crime report, his or her investigation should be circumscribed to deal only with the essentials, and should not include a thorough interview of the victim. The appended Special Order on rape cases issued by the St. Louis Police Department (Appendix I-D) is a useful prototype for other departments devising their own procedures.

I. Taking the Victim to the Hospital

Elsewhere in this report (see the section on medical facilities) is a series of recommendations for improved medical treatment of rape victims. Where these or similar improvements have been adopted, it is the special role of the investigator to see to it that they are followed. Where emergency room treatment of rape victims is poor, it is the job of the investigator to document its shortcomings, to notify the police department of them, and to recommend appropriate corrective action. Suggested changes may include a meeting between police officials, hospital administrators, and representatives of the prosecutor's office to develop improved policies, joint training sessions for police and hospital personnel, or other such actions. If the investigator is unable to initiate remedial policy changes, he/she should work around poor procedures as much as possible, using such informal means as are available.

At least one study shows that rape victims feel a higher level of animosity towards the medical staff who treated them than towards the police who interviewed them.[4] But a victim angered over her treatment at the emergency room may then decide not to cooperate in further official procedures necessary for investigation and prosecution.

There are several ways in which the police officer may alleviate some of the factors that antagonize victims. "The Response of Medical Facilities," Section 2 of this book, outlines in detail the procedures that are, or should be, followed during the hospital examination of a rape victim. A knowledgeable investigator can help hospital personnel realize at each step throughout the procedure that the rape victim's emotional crisis should be taken into account.

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[4] Ann W. Burgess and Lynda L. Holmstrom, "Accountability: A Right of the Rape Victim," (Paper read at the American Orthopsychiatric Association, San Francisco, California, April 11, 1974): 8.

The visit to the medical facility has a dual purpose: to attend to the victim's medical needs and to collect evidence for possible prosecution. It is this last factor that makes the investigator's involvement with the hospital visit so important. Unless the hospital staff can be relied on to automatically collect and preserve the best medical evidence relating to the crime, the investigator must take every precaution to see that the case is not destroyed in the examining room.

1. *Initiating a policy review of hospital practices.* Since the law enforcement mission includes the careful preparation of evidence for the prosecution of offenders, the leadership of police departments should undertake a systematic study of the workings of local emergency rooms. Such a review should focus on the effects of the hospital's services on the attitudes of rape victims as well as on the collection, analysis, and preparation of evidence. A few departments employ or contract with their own doctors, who are the attending physicians at the hospital in sexual assault cases. Even these in-house arrangements should be evaluated periodically.

Police department leaders should also study the adequacy of the laboratory facilities used to analyze medical evidence and the procedures entailed in the chain of evidence. Here the options are broader. Police departments have made use of hospital laboratories, their own forensic labs, regional police labs, the FBI lab, or private labs. Even if improvement means shifting the responsibility for lab workups out of the police department, that option should be given serious consideration.

With both of these studies, police departments should seek to make formal, interagency agreements over the way medical services are given rape victims—down to and including procedures that investigators should follow to monitor the provision of those agreements. In working these out, departments may find that local prosecutors and citizen action groups are effective allies. But departments should not shunt the job off as being "their" responsibility—every law enforcement agency has a direct, legitimate, and professional concern in the way its victims and its evidence are handled. Protocols for the collection of evidence and the examination treatment of rape victims do exist. These are described in the section of this report on medical facilities.

2. *Enlisting supportive help for the hospital visit.* Although the conscientious investigator will want to stay for the duration of the victim's hospital visit, this is not always feasible. Even if it were, the investigator should seek to have others on hand to make the visit more tolerable. It may be especially helpful to enlist women for this supportive role if the investigator is male. The sections on medical facilities and citizens' action groups describe the many types of support that may be provided by hospital personnel, rape crisis center volunteers, or family and friends of the victim. Note, however, that it is unlikely that any of these aides can fill in for the investigator in monitoring the proper collection of evidence.

3. *Pre-examination procedures.* The investigator should seek to achieve three objectives on reaching the hospital.

First, the victim should be placed away from the waiting area of the emergency room. The sight of patients awaiting emergency attention is often upsetting to other patients; it can be especially upsetting to rape victims whose injuries are compounded with deep emotional stress.

At this point, the investigator should ask the victim whether she has ever had a gynecological examination, explaining that the question is asked for her benefit, not for police reports. If she has not, a nurse or victim counselor should be asked to explain the procedure.

Next, the investigator or aid, in having the victim checked in, should try to fill out the admission forms. Courtesies such as these constitute decent and surprisingly effective law enforcement services.

And third, the investigator should attempt to have the victim attended to quickly. This is essential both for the victim's benefit and for the investigator, who cannot wait at the hospital for extended periods of time.

These procedures will be more workable if they are spelled out in an agreement between the hospital and the department. But they also can be worked out informally through the patient efforts of members of the investigative unit working with the hospital staff directly involved.

4. *The examination*. Normally, even a female investigator will be excluded from the examination room when the victim is being examined and treated, unless otherwise mandated by law. Therefore, the investigator should have a written form or, better, a "rape kit" for use by the examining physician, unless these are already available at the emergency room. Use of such forms or kits will help to insure a methodical and thorough examination.

The investigator should get back the form or the kit immediately after the exam to insure that it has been completed properly. It is important that the physician has noted all evidence indicating that force had been used. The only chance the investigator will ever have to spot any discrepancy, error, or omission and act on it is just at this time. This review is advisable even when the form or kit is returned to the hospital staff for laboratory workups.

The investigator should attempt to have the nurses assisting the doctor discreetly serve as "quality control" in the examination room. One way to get this kind of cooperation while getting another important job done is to have the nurse take photographs, preferably Polaroid, of all visible injuries the victim has sustained. After the photographs are developed, both the nurse and the victim should sign the reverse side and indicate where and when the pictures were taken. The nurse should be made aware that if the case goes to trial she will be subpoenaed as a witness. Teaching the nurse the mechanics of this task is an excellent opportunity to have her learn the purpose of all the evidence sought in the exam. And, having these photographs taken at the hospital can be preferable to having them taken later at the police station. However, if the light conditions of the room are poor or bruises have not shown up quickly, this procedure should be delayed. The investigator should weigh the evidentiary concerns against victim comfort on a case-by-case basis.

Nurses should also be trained to look for and preserve other physical evidence, such as grass and paint chips on the victim's clothes.

If possible, all the investigator's extra supplies (camera, rape kits, and changes of clothes) should be stored at the hospital, assuming arrangements are made for their security.

The investigator should make certain that the initial steps in preserving the chain of physical evidence (described in Section 2–The Response of Medical Facilities) are taken by the appropriate hospital staff. He or she also should check to make sure that arrangements for performing the laboratory work and for delivery and pick up of the evidence are in order.

And finally, the investigator should insure that the victim has suitable transportation available after her examination, and should arrange with the victim a convenient time and date for her to come in for the follow-up interview. He or she should give the victim a business card[5] with a request that she call if unable to make the appointment. The investigator also should make certain that the victim has the necessary transportation for the trip and, if not, arrange for it.

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[5] Some departments prohibit officers from dispensing personal cards to victims because of possible misuses, with the result that officers often leave the victim their name and phone number on scraps of paper. It would be helpful to victims if these departments would permit officers to hand out appointment cards with the name, phone number, and location of their unit printed on the card. The officer could fill in his/her name and the time of the scheduled appointment, which would leave no room for doubt as to this card's purpose.

5. *Alternative procedures*. If the victim has been hospitalized first, the investigator should go there, consult with the medical staff, and, if possible, talk to the victim. If her injuries are substantial, and she is being treated as an in-patient, she is normally unable to give an interview then, but an appointment can be made. If she is to be released, the investigator can drive her home and assess whether an interview is appropriate then.

If the victim chooses not to continue the interview process at this time, the investigator should leave her a card with his/her name, unit, and phone number. Rape victims often move or stay with friends because they fear the rapist will return, but do not always notify the police. If the investigator cannot locate the victim, he or she will be forced to close the case, but if the victim knows where to reach the investigator, the chance of this misunderstanding is lessened.

In rare cases, the victim will be willing to continue working with the investigator even after the interview and the hospital treatment. If it would materially help the investigator to do so, it is appropriate to start some of the follow-up procedures at this point, such as the use of a photokit.

J. Follow-Up Investigative Work

The following section describes basic, familiar police procedures, with an emphasis on the victim's welfare. Sensitive treatment of the victim is important both as a matter of human concern and as an essential factor in eliciting the most accurate imformation from the victim.

The text assumes that the same investigator who conducted the earlier interview will be meeting with her the second time, that no suspect is in custody, and that the victim does not know her attacker, but that she had an opportunity to see him reasonably well. Exceptions are covered in the last subsection.

1. *Preparing for the follow-up interview*. The investigator should research the MO files to match all possible suspects against the victim's testimony in the interview.

The investigator should prepare a photo lineup, if there appears to be a prime suspect who is not now in custody. Unless the investigator is experienced and has been well trained in photo lineup procedure, the lineup should be approved by a supervisor. Additionally, a joint police-prosecutor policy should be established on this procedure to avoid evidentiary problems at trial.

Alternatively, the investigator should have a photokit or a police artist or, less preferably, an Identikit available for the interview. Similarly, the investigator should prepare a set of mug shots, edited to exclude obviously inappropriate suspects. It is important to expose the victim to as few mug shots as possible.

The investigative unit's secretary should prepare a transcript of the earlier interview, or the investigator should prepare a statement based on his/her notes. The statement should then be reviewed by another investigator, or, if possible, by the investigator's supervisor. A third-party review of the statement will serve as a useful check on the investigator's own analysis and will help to spot flaws in the victim's account, or investigative leads may have been overlooked. Based on this review, the report should be readied as a statement for the victim to read, correct, and sign, or, alternatively, a list of follow-up questions should be prepared to resolve any ambiguities, discrepancies, or omissions in the statement. The goal of this approach is to avoid the need for going over the same story to produce a complete statement for police and prosecutor use. If the first interview did not produce enough information to meet the goal, at least it should be possible to narrow down the issues that deserve to be examined further.

A second, thorough interview by a different investigator should be avoided. (This recommendation runs counter to what many law enforcement officials consider to be the best procedures in investigating all other major felonies.) There is, however, one exception: if, after reviewing the report of the first interview, the investigator and his/her colleague and supervisor have reason to suspect that the rape charge is unfounded, it is appropriate to have a second investigator conduct another complete interview. The recommended procedures for unfounding rape cases, discussed in a later section, should then be followed if appropriate.

Finally, the investigator should see to it that all of the steps outlined are followed very quickly so that the second interview can be conducted within a day or, at most, two, of the first interview. Clearly, this necessitates the mobilization of resources in a concentrated fashion as soon as the initial interview tapes or notes are turned in. A lapse of time is the enemy of successful police work. For the second interview to produce new and helpful leads, it should take place within 24 or 36 hours of the event, if at all possible.

2. *Conducting the follow-up interview*. Once more, the first consideration is the victim's comfort and the privacy of the interview. It is well to consider asking the victim where she would feel most comfortable, as most victims usually find police stations unfamiliar and less-than-relaxing settings. Holding the interview at the victim's home is often appropriate. If this is not feasible, it helps to provide transportation for the victim and to locate a private office for the interview.

Even when the first interview has produced an acceptable statement, the investigator should go over the statement slowly and carefully with the victim, again testing the victim's memory for identifying characteristics of her assailant, before having her sign it. However, it should be made clear to the victim that this is to assure accuracy and not to cast doubt on her credibility.

If the need for follow-up questions has been established, both the general statement and the specific questions should be examined in the interview.

The next task, unless the victim knows her assailant, is to obtain a picture of the rapist's face by using a police artist, photokit, or identikit. This should always precede a review of mug shots, since looking at the latter will invariably blur the victim's recollection of the assailant's features.

Next, conduct a photo lineup if a prime suspect has been identified. Because of the major significance of this procedure for prosecution, the selection of photographs to be used for the lineup should always be reviewed by the investigator's supervisor if the investigator is inexperienced and, possibly, by the district attorney's office.

If a victim selects a photograph of the suspect, she should sign and date the back of it. Because all the photographs in the lineup will be vouchered for court, additional negatives should be printed (or Polaroid reproductions made) for inclusion in the original file until these photographs are returned from court.

Normally, however, a less focused search for a suspect, based on an examination of pictures of past sex offenders and suspects, will be needed. It is recommended that the victim's review of mug shots be limited to those which partially meet her description of the attacker, rather than having her examine every picture in the file. Mug shots from other crime files, such as robbery and burglary, of offenders fitting her description should also be shown to the victim when appropriate.

3. *Improving the quality of mug shots*. More than in other serious crimes, rape investigations are dependent on a link between the victim's memory of her attacker and a photographic gallery of past sex offenders and suspects. The better the quality of those photographs, the better the chances are that the victim can identify her assailant.

One important method of improving the quality of those pictures is to have every male arrested on a sex charge (including a "Peeping Tom" charge) photographed in color as well as in the normal black and white.

As an extra resource, it is recommended that the rape investigator have 8- x 10-inch enlargements of these arrestees made up for the sex offense mug book or use slides projected onto a screen for viewing by the victim.

Finally, if in the process of looking at mug shots the victim narrows down the list of potential suspects but then cannot decide, retrieve additional photographs of those men. In addition to the full-face picture used in a book of mug shots, most departments also have profiles and full body pictures of arrestees. The FBI may have other photographs. And, if the whereabouts of a suspect is known, and if local laws permit such a procedure, it may be helpful to have the victim observe the suspect at a location where other people are gathered.

4. *Alternative procedures*. If the police have a suspect in custody, the standard procedure is to have the victim try to identify him in a live lineup, not a photo lineup, if for no other reason than the greater effect such testimony has in a trial. There are two exceptions to that general rule: (1) when the suspect has changed his appearance since the time of the offense, using a photograph of him in his previous appearance may be required and (2) when a strong case has been established on extrinsic evidence (fingerprints, etc.), having a lineup for a victim whose memory of her attacker is not clear may be both unnecessary and tactically questionable.

This raises the issue of two other kinds of suspects—one whom the victim cannot ever identify well (such as one who attacked in the dark, who blindfolded his victim, etc.) and one whom the victim can identify because she knows him (a relative, an acquaintance, etc.). In cases of "unknowable" and "known" suspects, the victim should be asked to sign a complete statement. Regarding unknowables, the victim should be checked and rechecked for the recollection of possible clues.[6] And even with known suspects, a lineup may be appropriate to solidify the case if there is any question of identity of the suspect. In either of these extreme types of cases, the amount of time needed for the second interview should be considerably shorter than for the others.

Finally, it is almost always preferable to have the same investigator who conducted the first interview do the follow-up interview (except, of course, when the first encounter produced a poor relationship between them or the victim requests to speak to someone else). If the follow-up interview must be conducted by another investigator for these reasons (or because of investigator work schedules) the first investigator should try to learn who the second investigator will be, brief him or her, and "introduce" the victim to the new investigator, if only through a telephone conversation.

K. The Modus Operandi File

Whether or not rape is usually a crime of repeaters (there are no definitive studies on this issue), it is known that at least some individual rapists commit multiple offenses. Most of the investigative search for unidentified rapists is directed to that group of men known to the police as having committed sex offenses, or who were suspected of doing so in the past. The law enforcement tool for methodically sifting through the histories of this group is the MO file.

Strictly speaking, an MO file is a way of classifying the behavior patterns of these men—literally, it describes their "manner of operating." However, law enforcement staffs also use this term to describe ways of classifying potential offenders by physical characteristics and other identifying traits.

Every department, whether or not it has a specialized rape investigation unit, should develop, update, and improve an MO file for sex offenders. The raw material for this file is made up of the men in the area who have been convicted of such offenses, those who have been arrested on such charges, and others whose identity may be unknown but who have been described by rape victims—plus all the physical, behavioral, and other identifying characteristics associated with each such person.

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[6] In jurisdictions where the technology is available and local laws permit, voiceprint identification should be considered. A rape victim who was blindfolded or otherwise unable to identify the assailant may be able to recognize his voice.

Although the basic file may be arranged alphabetically (for known individuals) or chronologically (for unknown suspects reported to the police) each file should be cross-indexed to other files that have been set up according to the following categories: geographic locales of reported sex assaults; the age (or approximate age) of men in the master file; their height, weight, and race; notable physical characteristics (hair style, scars, moles); their dress; their automobile; notable behavioral characteristics (method of entry, use of weapon, the method of applying force, the use of sodomy, postcoital behavior); their "moniker" (first names, nick-names); and monikers of friends or collaborators.

With every new case, the new suspect's identifying characteristics are entered into the master file and into each cross-index file for which there is relevant information. In the process, each new entry is checked against prior entries and any match is examined in more detail to see if the new suspect and the formerly identified individual could be the same person.

1. *Geographical scope*. The master file and cross-indexes constituting the MO file should be centrally housed and should cover the widest geographical area possible: the city, the county, even a multijurisdictional, metropolitan area. Broad geographic coverage is important since rapists do not necessarily restrict their attacks to a limited area but may move about.

Decentralization of information is relatively easy to accomplish. The danger lies in not getting that information in a place where others can use it.

In some situations, formal personal contact may have to be a substitute for a common, centralized MO file. For example, investigators working on rape cases near a bordering jurisdiction should periodically meet and exchange information with their counterparts in the next jurisdiction, especially whenever a new crime occurs near that common border. This type of information exchange should be legitimized by written orders issued by each of the participating departments.

2. *The use of computers*. The MO file requires the kind of information storage, retrieval, and analysis that computers do well. In looking for a suspect, say, who is white, about six feet tall, between 25 and 30, has a scar near his left eye, a computer can comb several files or cross-indexes faster and better than a person can.

This underscores the importance of the New York City and Los Angeles experiments in computerizing MO files. When MO computer experiments succeed, that technology should be replicated in every large police department and in other multijurisdictional agencies.

3. *Clearing old cases*. Many rape investigators find that the major payoff of a good MO file is in clearing open cases once a new suspect is arrested; the mug shots and the crime lab seem to be more helpful than the MO file in putting a name on an unknown rapist.

It is therefore important to check out the possibility that a new arrested person in any sex case may be responsible for unsolved sex crimes by matching him against open cases in the MO file. Where other cases are cleared by new arrests, it is essential to establish corroborating evidence linking the suspect to each crime. A field inspectional audit of the closing of these cases is appropriate to safeguard the rights of the suspect and to check abuse of the record system by investigators.

L. Apprehending Known Suspects

When the victim knows her assailant, the police response requires much less specialized detective work. This section is abbreviated to point out the investigators' special responsibilities as coordinator of standard police practices.

Whenever a known individual is being sought in a major felony case, virtually every law enforcement agency has standard procedures it follows to apprehend the suspect. Having a warrant issued, dispatching to the patrol force and neighboring jurisdictions the suspect's picture and descriptive material about him, checking out known friends or hangouts of the suspect, and checking with street informants are examples.

Working through regular channels, the investigator should insure that all regular efforts, plus any extraordinary ones that seem appropriate, are made in finding and arresting a known suspect.

M. Seeking the Unknown Suspect

Again, recommended police procedures in this area are generally standardized and are familiar to most departments. Moreover, the specialized techniques of using photokits, mug shots, and the MO file have already been discussed. Yet there are three additional tools of rape investigators that merit brief discussion even though they are by no means unique to rape cases.

1. *Stake-outs and decoys.* Investigators should consider using stake-outs and decoys in exceptional situations, such as when a rapist has made repeated attacks in a relatively small geographic area and at approximately the same intervals and times of day, or when such a person has revictimized the same women. However, this is an expensive use of resources and does not appear to be highly productive.

2. *Distributing information to patrol.* It is desirable to provide all patrol officers with all the descriptive material developed in each case, such as a photokit picture, and automobile description, etc. Although these are long-shots, given the relative numbers of patrol and their dispersal throughout the population, the odds favor their eventually spotting even sketchily described suspects. The investigator, therefore, should insure that this lookout is in the hands of every patrol officer.

3. *Using the police lab effectively.* Well-trained investigators have a solid understanding of what police laboratories can do to break a case or strengthen one. Rape investigators should work closely with lab technicians in exchanging ideas and finding areas where scientific investigation or analysis will advance a case.

For example, a partial fingerprint found at a rape scene is, by itself, not much help to the police. But if the fingerprint analysts have a limited number of prints to check the partial one against—prints supplied from the mug shot and MO files—the lab can be made a more productive partner.

Another example is from an actual case in which the investigator noticed that the assailant had to go by a freshly painted fence to get to and from his crime scene. The investigator asked the lab to check for paint on the clothing of a suspect taken into custody. It was there, and it strengthened the case immeasurably. Similar evidentiary breakthroughs have been made by finding and analyzing footprints, fingerprints, hair, fibers, and, of course, semen.

N. Handling Arrested Suspects

1. *Photographing suspects arrested on sex charges.* The rape investigative unit should have cooperative procedures worked out with the officers who process arrestees so that those charged with sex offenses are photographed in color. Men charged with consensual but illegal sex acts with adults in private are not normally of interest to rape investigators. However, arrestees charged with disorderly conduct ("Peeping Tom"), child molestation, or forcible sodomy, as well as those charged with forcible rape or attempted rape, are appropriate subjects for full-color photographs. The obvious exception, of course, is juveniles; legal restrictions may prohibit departments from taking and preserving the photographs of juveniles or merging juvenile records with the rape unit's MO files.

2. *Questioning the arrestee.* As experienced investigators know, effective interviewing of arrestees did not expire with the handing down

of the *Escobedo* and *Miranda* decisions protecting the right of the accused to be advised by counsel. For the fact is that these and related decisions permit arrestees to knowingly waive their right to counsel, to talk to the police, and to have such evidence used in court against them. This continues to happen in rape cases.

Rape investigators should usually seek to take a statement from men arrested on rape charges; some will knowingly waive their right to counsel, and, of these, some will provide police with convincing exculpatory evidence, while others will provide testimony that ultimately tends to be incriminatory.

As a general proposition, the arrestee's denial of involvement may work against him, because the details of his version of the story are refuted by other evidence. In rape cases there is often an additional value in getting the arrestee's protest of noninvolvement on the record: the defendant who has claimed that he never even knew the victim has considerable difficulty later defending his relations with her as being consensual in nature.

O. Exceptionally Cleared and Unfounded Cases

There are two types of "exceptionally cleared" cases: those in which the victim refuses to cooperate with the prosecution of a defendant, and those in which the prosecutor (or grand jury) refuses to press charges.

"Unfounded" cases are those so designated by the police (sometimes after consulting with the prosecutor).

1. *Victim noncooperation*. Police officials have little direct influence over victims who won't report an offense or delay reporting it. But, police can and should take steps to understand the reasons for victim noncooperation and to diminish it.

First, the department should prepare an internal report on every rape case that it dropped because the victim chooses not to prosecute, and that report should be drawn up by an officer who is not a member of the rape investigation unit. Whether or not the department has a separate inspectional services unit, an audit trail should be run on every such case to obtain a disinterested assessment of actions by the police and others in an attempt to understand how different actions might have sustained the victim's cooperation.

The command structure of the department should use these reports as opportunities for taking corrective actions. This may mean a review session between a rape investigator and his or her supervisor, or it may lead to additional roll-call training of the patrol division, to substantial procedural changes, or to police-level discussions between the department and the local hospital or prosecutor's office.

2. *Nonprosecution*. Again, it is important that the department understand the reasons behind prosecutor or grand jury refusal to prosecute. This information should be obtained directly from the prosecutor involved.

One typical reason is that, despite evidence that the defendant committed a crime, the circumstances of the case mitigate against getting a conviction; for instance, perhaps the victim was a prostitute, the assailant was her boyfriend, etc. In these cases there is little chance of conviction because of predictable community attitudes towards the victim. Officials from the police department and the prosecutor's office should periodically review these cases to make sure that they are all appropriately labeled as not prosecutable. Cases that weren't prosecuted for lack of evidence should be analyzed in hopes of finding ways to improve rape investigations.

These review sessions should also deal with two policy questions. First, if all charges against defendants in these cases are being dropped, the reviewing body should analyze whether lesser included offenses (such as assault) or related offenses (such as robbery) might nonetheless have been prosecuted. The department has a direct interest in curbing this use of prosecutorial discretion: nothing turns investigators into cynics more rapidly than having their cases washed out unnecessarily–and that kind of cynicism produces inferior investigators.

Second, a [illegible] victim whose status (prostitute, hitchhiker, [illegible].) subjects her to special scrutiny, has suffered a terrifying and violent crime, one that a decent society will not simply ignore. Thus, the joint police-prosecutor reviewing body should examine ways in which even rapes that might be thought to have been precipitated by the victim can be successfully prosecuted. One promising approach to this problem is the recently enacted Michigan statute classifying a wide range of sexual assaults. If the issue put to a jury in a difficult case is not whether the defendent committed a capital offense, but whether he committed a misdemeanor-level assault, the jury may be more inclined to find him guilty even if it is not certain that the victim was entirely blameless.

It is in just this kind of policy-related area that police, prosecutors, and legislators should take steps to involve such groups as citizens' rape task forces in the development of corrective legislation. (See the section on citizens' action for a discussion of rape task forces.)

3. *Unfounded cases*. Some police departments have used the "unfounded" label to reduce the rate of reported rapes with the stroke of a pen. Others have used this category to reduce the number of open cases. And still others have allowed this label to cover inappropriate, prejudicial judgments by their officers. All of these dangers can and should be countered with firm procedures to insure the integrity of every unfounded report.

First, no case should be unfounded except on the basis of some extrinsic evidence in addition to the seeming intrinsic lack of credibility on the part of the victim. Without this corroboration, the department should treat the case as open, unless and until it is closed through prosecutorial action or other means.

Second, neither the investigating officer nor the investigative unit should unfound a case; rather, the unit's recommendation should be reported to the chief or his/her designee for a final determination.

And third, at no stage in a case is it necessary or advisable to indicate to the complainant that she is not believed. Any discrepancies and inconsistencies can be put to her in neutral terms for her comment. The trauma of rape impels many victims to tell their stories as they think they ought to sound, not as they happened, and thus "lying" is an inescapable factor in at least some real cases of rape. "Lying" may center around the victim's efforts to protect herself from shame or embarrassment. Most often this occurs when the victim feels guilty about the type of initial contact she had with the offender, or when she does not want to admit that she was a victim of sodomy. If the investigator assures the victim that this information will be treated confidentially, she may be better able to cope with the source of her distress and thus be more candid with the investigator.

Ridicule must be barred from police interview techniques, and every other means of expressing disbelief. Police behavior in handling the unfounded case should be so professional that the victim is not resentful when she is told that her account is so at variance with other evidence that the department is unable to conclude that a crime has been committed.

Some departments have asked complainants whose cases may be unfounded to come in for a second interview by a different investigator. As onerous as this may be for the complainant, if the interview is properly conducted it will serve to protect her interests as much as the department's.

During this second interview, or during the first in-depth one, the skilled investigator can often sense problems of victim credibility. He or she should pursue these leads without making the victim feel she is being attacked. A typical clue that might start this exploratory process is the victim's inability to recall facts and events even prior to the crime.

After exploring the possibility that a report is unfounded, the investigator should next examine the victim's possible motives for filing such a report. False reports can be a call for help. If the investigator's manner is not judgmental, he/she is more likely to develop a confidential and understanding relationship with such victims and may obtain important motivational clues. Typical kinds of human problems that may be uncovered by a dispassionate approach are that the victim's parents refuse to believe that she could engage in consensual sex, the victim is unmarried but pregnant, or she has lost her virginity but not to her fiancé.

When circumstances brought out in the interview reinforce the possibility of an unfounded report or describe a shaky case, the investigator can summarize in a nonthreatening manner those circumstances for the victim. He or she should indicate that these suggest that the victim has a serious problem—a problem similar to many other women's problems, but one that is not likely to be best handled by a law enforcement agency.

This is usually the key stage of the interview: if the complainant has come to feel that the discussion is indeed being treated in confidence, that the investigator is sympathetic even though a crime is not indicated by the evidence, and that the investigator continues to want to help the complainant with her problem, the complainant may well be eager to seize the opportunity to unburden herself of her false story.

The investigator will be of better service to such complainants if he/she has developed working relationships with community agencies that can perform valuable follow-up services for her. Birth control clinics, family counseling, and other social, medical, and mental health agencies are among the services likely to be helpful.

On the other hand, not infrequently a complainant's initial report will be inaccurate, not because a crime did not occur but because, in her state of stress and confusion, the complainant related what she sensed the police wanted to hear. It is important for the investigator to remain open-mined and nonjudgmental in interviewing any complainant whose initial story is puzzling.

P. Research Tasks

This report has been based on too many guesses—informed guesses, but guesses nonetheless. The little research done on rape has been mostly basic social science research; with a few striking exceptions, few studies or evaluations, either completed or underway, are immediately applicable to police work. Law enforcement research units, plus local, state, and national criminal justice research and planning bodies, should correct this deficiency.

Many departments have the capability to empirically test many of the assumptions inherent in the recommendations of this report. Research grants might be obtained for evaluation of these or other hypotheses about the most effective ways of responding to the crime of rape.

Among the most important research topics deserving study are the following:

- What is the optimum system of collecting, storing, and retrieving MO data?
- To what degree is rape a crime of recidivists?
- Is nonreporting concentrated among certain populations, such as minorities? What techniques will increase both the rate of rape reports and their timeliness?
- How do victims react to interviews by male investigators? Female investigators? What operational significance is there in the difference, if any?
- Do factors other than the investigator's sex (such as age, maturity, experience, or personality) play a role in police effectiveness? Can practical guidelines for the selection of officers best suited for rape investigation be developed?
- In what ways does the victim of rape inadvertently contribute to her victimization? What lessons can be drawn to help prevent such attacks?

- What cost/benefit consequences are there, if any, in having rape investigators respond to the victim's first report?
- Are there patterns of victim response to attempted rape and rape? If so, do they have any application to rape prevention education?
- What types of rape cases do prosecutors fail to charge? Why?
- Is there a generalizable profile of the unconvicted rapist? The convicted rapist?
- What are the practical consequences for the police, prosecution, victims, and rapists of recent changes in the legal definition of rape, evidentiary rules, and statutory mandates affecting the police role and structure?

Q. Relationships with Public and Private Agencies

Theoretically, the burden is on law enforcement agencies to catch criminal suspects and develop evidence of their guilt or innocence. To an unusually high degree, the crime of rape belies that theory: the police department is often dependent on others—the hospital, the prosecutors, the legislature—to make its cases. Its work is also often dependent on the attitudes of the victim and her family and friends, and it is frequently influenced by the activities of citizen action groups.

Some recommendations for improving working relationships with hospital, prosecutor, and such citizen groups as a rape crisis center follow. Police relationships with the press and the general public are also discussed.

1. *Dealings with the hospital*. Police officials should learn from both victims and investigators about deficiencies in hospital treatment of rape victims and seek to promote needed improvements. Several suggestions appear in the hospital and medical facilities sections of this report. Police have a strong interest in seeing that rape victims are treated humanely, thoroughly, and rapidly at the hospital. Police also need quality in the collection, preservation, and analysis of physical evidence. In addition, it is essential that the medical personnel responsible for examining the victim and collecting the evidence also be available, as needed, for testimony in court.

Experience suggests that there is generally room for improvement on both sides, and that hospital personnel are as willing as police to discuss ways their procedures can be improved. It is essential that this dialogue begin, and that it be entered forthrightly and with a tolerance of the other side's misgivings, misconceptions, and concerns. Approached in this manner, it should be possible to develop new policies, working agreements, and practices that will benefit the victim and enable police and physicians to do their tasks better.

Another area for collaboration is training. The department should request the participation of hospital administrators, physicians, nurses, or other appropriate medical staff at its in-service or recruit training. If invited, it should encourage its experienced investigators to participate in hospital-sponsored training programs.

2. *Dealing with the prosecutor*. The investigative unit should maintain records of all cases that are closed for lack of evidence or because the prosecutor or the grand jury felt the chances of conviction were too remote. Police department staff and staff from the prosecutor's office should meet periodically, as a joint committee, to review these cases. If conducted in a spirit of cooperation, these meetings will create opportunities to define deficiencies in the department's investigations, to identify possible mishandling by the prosecution, and to develop procedures to minimize the risk of similar occurrences in the future. They will provide police with occasion to discover and discuss the merits of policies governing the prosecution of rape cases. In addition, the joint committee should seek to fashion new policies or legislation aimed at deterring attacks on those victims less likely to gain sympathy, such as prostitutes.

The department should encourage the participation of representatives of the prosecutor's office either in joint training sessions or in-training programs conducted for police personnel.

3. *Dealing with rape crisis centers*. Although many police departments have had quite strained relations with rape crisis centers and similar organizations that have pressed for change in the treatment of rape victims, such groups should be treated as allies in the department's efforts to improve its performance and that of other involved public agencies. The fact is that these women's groups have proven far more effective in bringing about reform than have most public agencies; the conscientious police official seeking systemwide improvements should take advantage of this. Police administrators are urged to review the discussion contained in the section on citizen action.

Police departments and rape crisis centers can work out mutually supportive operations and referral systems. For example, the center can provide volunteers to accompany victims to the hospital, provide crime analysis data on rape reports that victims refuse to give to the police, encourage victims to report attacks to the police, accompany victims to court and provide moral support, steer victims to social services, and improve community awareness about the crime and the steps needed to combat it.

None of these will be easy to accomplish if the center regards the department as a cause of the problem, not a source of solution. Yet open-mindedness and sophistication from the departmental leadership can help overcome hostility. The potential benefits of constructive relations with a center certainly outweigh any difficulties involved in achieving them.

4. *Dealing with the general public*. There are three levels at which a department can work effectively to communicate with the public about the crime of rape.

First, the departmental leadership should seek to establish reasonable editors' guidelines with local newspaper publishers and news broadcasters. Most news media make it a policy not to publish the names of rape victims. Similarly, news executives will often insure that some crime reporting, however newsworthy, is not sensationalized, especially if it can harm the victims or law enforcement agencies.

Second, as the department develops general policy and concrete procedures for handling of rape cases, it should "go public" with this information. Perhaps in no other area has there recently grown so much serious-minded public interest in law enforcement. A full-disclosure policy is likely to attract a surprisingly large, sophisticated audience that can appreciate the difficult choices a department must make and will support fairly reasoned solutions.

Finally, departmental staff should seek invitations to speak about rape prevention and prosecution to civic groups, women's groups, campus organizations, and so on. Such discussions can publicize ways in which women may avoid some kinds of sexual attacks, explain the department's techniques for responding to reported rapes, and help to demystify a topic that until recently was practically taboo. By accelerating a change in social attitudes toward rape, law enforcement agencies can play a major role in encouraging victims to report the crime promptly, in effecting cooperation with law enforcement and prosecution, and in providing prospective jurors with a more rational understanding of the crime. They may also help discourage such assaults by increasing the likelihood that rapists will be brought to justice.

SECTION 2

THE RESPONSE OF THE MEDICAL FACILITIES*

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*Research performed by Legal Resources, Inc., Washington, D.C.

CHAPTER IV. INTRODUCTION

Because rape is a crime of violence that usually results in some physical injury, and because the proof of the crime requires evidence that can only be obtained by a medical examination of the victim, the increase in the prevalence of rape has meant that its public health aspects are of growing community and medical concern.

The purposes of medical treatment include treatment of the victim's physical injuries, collection of evidence for future prosecution, prevention of pregnancy, treatment and preclusion of infection, and prevention of psychological trauma. Thus, medical treatment is a most important part of the process a rape victim goes through.

Much recent public attention has been directed at the institutions rape victims must confront if they report the crime and prosecute the rapist to the full extent of the law. Criticism has been levied at police departments, hospitals, and prosecutor's offices for their alleged insensitivity to the victim's emotional state and for the perpetuation of moralistic attitudes and societal myths that add to the victim's trauma.

A capsule version of typical criticisms against medical facilities makes these points: A rape victim is usually brought to an emergency room of a large public hospital, which is crowded, confusing, understaffed, and overworked. She has to wait a long time for treatment, perhaps up to four hours, sitting in soiled clothing after a lengthy police interview. Receptionists, under other institutional stress, snap at her. People awaiting treatment gawk at the victim and her police escort. Doctors make snide remarks as they examine her. The medical examination is unexplained and uncomfortable. Nurses let her know what they think of women who "ask" to get raped. Police, doctors, nurses, and clerks all are trying to get information from her, but no one asks how she is feeling. She is treated as an accused, as if she did something wrong. She leaves the hospital alone, to return home, frightened, confused, dirty, and distraught. She was raped in private during the crime: she has now been raped in public.

In response to these criticisms, several communities have developed programs attempting to correct some aspects of the treatment rape victims have endured. The next chapter reviews innovations in the response of medical facilities to rape, which were found to be in use during the summer and fall of 1974. The material is based upon information gathered by Legal Resources, Inc. from site visits to 19 medical facilities, plus mail or telephone contacts with approximately 20 others.

The third chapter presents guidelines based primarily upon the results of the national survey of medical facilities with progressive programs. In addition, the guidelines incorporate substantial amounts of information and advice provided by a panel of medical personnel and community persons knowledgeable about the public health response to treatment of rape victims, plus results of discussions with a number of rape victims.

In the course of preparing this material, some general observations were made:

- Cooperation among all institutions dealing with rape victims is a relatively rare phenomenon. Most changes have taken place within one institution, with a ripple effect on other institutions if community pressure continues.

- No programs have attempted to look anew at the entire medical treatment process and its relationship to other institutions. Some programs are on their way to doing this, having taken a multi-disciplinary approach to the treatment of rape victims. The changes made as a result of this approach are impressive, but they are still in the preliminary stages. These programs are in the process of acquiring needed information before they can make recommendations for any radical alteration of the system. The present focus is on basic improvements within individual institutions.
- Most programs have made only cosmetic changes in their procedures, having recognized the formidable institutional barriers to real reform.
- Most improvements that have been implemented focus on the medical procedures that must be performed for a rape victim—preexamination process, medical examination, and follow-up procedure. Reforms have been in one or two of these categories, rarely all three. The improvements have not been drastic or particularly innovative, but are helpful and necessary.
- Only one program has attempted to deal with nonreporting victims who may need medical attention, and to uncover the reasons that victims are not reporting rapes.
- No programs in hospitals have experimented with providing different means of access to the medical and criminal justice systems that could be more acceptable to both disadvantaged minority group members and middle class citizens.

During the spring of 1974, to locate those medical facilities with innovative rape projects, an exhaustive literature search was made of medical, nursing, hospital, and feminist journals; national and local press; and media coverage. Ads were placed in relevant journals and magazines, the Law Enforcement Assistance Administration headquarters and regional personnel were contacted, and officials of the National Institute of Mental Health and leading national medical and hospital associations were telephoned. Names and contacts were gathered from programs that developed or were in the process of initiating innovative programs. Colleagues in the police, prosecutor, and citizen action units were also asking their contacts for names of medical facilities.

From all these sources a list of 40 to 45 promising leads was developed, which suggested many additional contacts. By means of a standardized telephone checklist questionnaire, each of these sources was asked about the type of facilities used; the type of personnel employed; the procedures involved in preexamination, examination, and postexamination; any special training given personnel; and coordination with community groups, police, prosecutors, and other institutions treating rape victims.

Based on the response, 19 medical facilities with special programs were selected for more intensive examination through on-site visits. A standardized questionnaire was administered to personnel within each of these 19 programs, seeking to refine and expand the information obtained in the telephone survey. This procedure and the questionnaires were site-tested in a pilot visit to Philadelphia. Visits to medical facilities were usually made by only one staff member, who ordinarily spent about one day with facility personnel and another day talking with other interested persons in the community, such as doctors, mental health personnel, visiting nurses, and knowledgeable citizens.

Medical Facilities Surveyed

Grady Memorial Hospital	Atlanta
Breckenridge Hospital	Austin
*Herrick Hospital	Berkeley
*Boston City Hospital	Boston
Beth Israel Hospital	Boston
*Green Point Hospital	Brooklyn
Albert Einstein Hospital	Bronx
*Morissania Hospital	Bronx
*Martin Luther King Health Center	Bronx
Hollywood Memorial Hospital	Broward County, Florida
Burnham Hospital	Champaign, Illinois
North Carolina Memorial Hospital	Chapel Hill, North Carolina
Billings Hospital	Chicago
St. Lukes Hospital	Chicago
Medical Center	Columbus, Georgia
*Institute of Forensic Sciences and Parkland General Hospital	Dallas
*Denver General Hospital	Denver
City Health Department	Houston
Johnston Municipal Hospital	Johnston, Wisconsin
*St. Lukes Hospital	Kansas City, Missouri
*USC Women's Hospital	Los Angeles
*Feminist Health Center	Los Angeles
Louisville General Hospital	Louisville
*Mt. Sinai Hospital	Minneapolis
Charity Hospital	New Orleans
Coroner's Office	New Orleans
Pontchartrain Mental Health Center	New Orleans
*Neighborhood Health Services	New York (100th Street)
*Hospital and Health Corporation	New York
University Hospital	Oklahoma City
*Huntington Memorial Hospital	Pasadena
*Philadelphia General	Philadelphia
County Medical Examiners	Portland, Ore. (Multanomah Co.)
*Emergency Hospital	San Francisco
*Harborview Medical Center	Seattle
Beakness Hospital	Spokane
Municipal Hospital	Stillwater, Oklahoma
*Ramsey Hospital	St. Paul
So. Ariz. Mental Health Center	Tucson
Tucson Public Health Department	Tucson
*D.C. General Hospital	Washington, D.C.

*Denotes site visit.

CHAPTER V. FINDINGS ON THE TREATMENT OF RAPE VICTIMS BY MEDICAL FACILITIES

A. Where Are Victims Taken for Medical Treatment?

When a rape victim reports the crime directly to the police, the usual procedure is for the police to take the victim or encourage her to go to a medical facility for immediate treatment.

Depending on the choice of the victim or the facilities available in the community where the rape occurred, the victim may be taken to a public hospital, private hospital, neighborhood health clinic, free clinic, university health center, health maintenance organization, or a private doctor.

Victims are most frequently taken to public hospitals. However, private hospitals are used often. Some treatment has been offered by neighborhood health clinics, free clinics, university health centers, and health maintenance organizations, but, on the whole, little treatment is available from such groups. Some of those seeking medical assistance may choose not to report the crime to the police. Such victims, as well as a small number of those who do report the crime, may seek medical assistance from private doctors.

1. *Public hospitals*. When the police have first contact with the victim, she is usually sent or taken to a public hospital. A few formal arrangements have been made between a particular hospital and municipal authorities for the treatment of rape victims and the collection of evidence, and the police, when feasible, take all victims to the designated hospital. A particular hospital may be more appropriate than another for the treatment of victims because it is conveniently located and has experience in dealing with rape victims; it has facilities for emergency treatment; it has the financial ability to devote special staff and facilities to a program; or it has a special ability to deal with the collection of evidence.

Unfortunately, specific arrangements are the exception and not the rule. Most police officers have difficulty finding a hospital that will treat rape victims. Hospitals have exhibited both reluctance to provide medical treatment that may involve later court testimony and disparaging attitudes toward rape victims. Therefore, most rape victims end up at the hospital that will accept them—a public hospital—because a choice of facilities usually does not exist. Most of our discussion will deal with procedures and programs within public hospitals.

Public hospitals traditionally are the most overcrowded, underfinanced, and bureaucratized hospitals. Those rape programs that have appeared in public hospitals may perhaps be there because these hospitals are more accountable to the public and should be more responsive to its pressure. Public pressure may have been a major factor in initiating rape programs. (See Section 4. The Response of Citizens' Action Groups.) Moreover, public hospitals may be recipients of public funding for reseeach or data-gathering that may relate to the treatment of rape victims. An example of such funding is the University of Southern California Women's Hospital menstrual extraction program.

However, large urban public hospitals, although they may offer services to rape victims, may have an image that discourages middle-class victims from coming in. These victims prefer the intimacy of a private doctor's office to the confusion of a large city hospital.

2. *Private hospitals*. Several police departments report that most private hospitals will not treat rape victims. Of those that do, most do so reluctantly. However, Herrick Hospital in Berkeley, a private hospital, is used by the police department for treating rape victims because of its excellent emergency facilities. A private hospital may be selected by the community as the preferred treatment facility. For example, in Kansas City a special rape program was placed in a private hospital because the public hospital had a full-time police officer, and anonymity of the rape victims from the police was not guaranteed.

In addition to the prevailing lack of emergency facilities or special facilities for treating rape victims in private hospitals, such hospitals also offer financial problems. Private hospitals usually charge a rape victim for the examination. The charge may range up to $75.00 for a simple examination with no complications. In Kansas City and at Huntington (Pasadena) Memorial Hospital, the procedure is to charge the victim, earmark the file, and not institute collection procedures if the bill is unpaid. This procedure, however, rewards the less diligent bill payer, rather than recognizing the inequity of charging rape victims. One solution to this problem was found in Berkeley, California, where the police department pays charges incurred by the victim if the police brought her in.

Another solution to the examination charges could be effective victim compensation laws, but, on the whole, these laws have been ineffective for the reimbursement of rape victims (See Appendix II-A, on victim compensation laws).

Movement is taking place in some communities to involve private hospitals in the adequate treatment of rape victims. In New York and Los Angeles, municipal task forces dealing with the overall problems of rape have attempted to get private, as well as public, hospitals to adopt special procedures for the treatment of victims. The medical society in Washington, D.C., has adopted standards and guidelines for the treatment of rape victims and is attempting to have them implemented by area private hospitals (Appendix II-B).

3. *Clinics*. Several clinics, including neighborhood health centers, free clinics, feminist clinics, and university health centers, were contacted to determine their involvement with rape victims. The neighborhood health centers visited in New York and Los Angeles saw few rape victims for medical treatment. This was partially explained by the fact that neighborhood health centers were usually located in lower income communities where the reporting rate to the police for rape was low. Moreover, because the majority of rape victims suffer little obvious physical injury, they may feel their need to seek medical treatment is not sufficiently great to overcome their alienation from hospitals and law enforcement agencies. In fact, in a study entitled "Sexual Assault: Signs and Symptoms," Ann Wolbert Burgess and Lynda Lytle Holmstrom[1] point out that the signs of both general physical trauma and gynecological trauma indicate a high percentage of injury that does demand medical treatment. Among adult victims of rape trauma, 63% evidenced signs of general physical trauma, and 43% evidenced signs of gynecological trauma. The percentages were higher for pre-adult victims. Finally, the priorities for treatment in limited-staff health centers did not include rape. Rat bites and malnutrition were of much greater concern. Consequently, no neighborhood health centers surveyed had adopted special procedures for treating rape victims.

The free clinics also treated few rape victims. Most of these clinics operate on a part-time basis and are usually not open when most rapes occur. Free clinics, even many of those with a feminist health clinic affiliate as in Berkeley, are involved with abortion counseling and other treatments, rather than specialized procedures for aiding rape victims. Victims that do seek treatment in free clinics may be members of a counter-culture and often choose not to report the crime to the police.

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[1] Paper read at the American College of Emergency Physicians and Emergency Department Nurses Association Joint Scientific Assembly, November 4, 1974.

University clinics and campus health centers had no specific rape programs that we were able to discover. The clinics visited reflected negative community attitudes more than did the larger hospitals and perpetuated myths and stereotypes surrounding rape. On one campus, the fact that students were being raped was not publicized nor were parents of rape victims called by the clinic because the clinic feared upsetting parents.

Teaching hospitals were the exception among university-affiliated health facilities. Some of the most outstanding programs visited were university-affiliated, such as Seattle's Sexual Assault Center at Harborview Medical Center. Such programs can combine the best of two worlds by offering excellent medical care and by perpetuating their methods through teaching future doctors.

4. *Private doctors*. The difficulties in obtaining statistics on the number of rape victims treated by private doctors are obvious. However, one study was located: a physician survey report conducted by Linda McGuire and Michael Stern in King County, Washington. Less than 50% of the private physicians surveyed by McGuire and Stern returned a questionnaire that attempted to obtain incidence data regarding the nature and extent of cases of sexual assault seen by physicians in private practice during a specified period, and to assess physicians' attitudes to several issues related to sexual assault. The physicians who answered saw 369 rape victims during the year 1973, with most victims going to their practitioner or family doctors.

> Contrary to the notion that women seen by private physicians constitute a vast hidden iceburg [sic] of unreported rapes, the majority of women treated did report their sexual assault to the police (57%). In 15% of the cases, this information was not known to the physician and presumably a certain percentage of these women chose also to report their rapes. A general feeling of willingness to cooperate with law enforcement agencies characterized physicians' responses to many items on this questionnaire. Only 37% would not support mandatory reporting of rape. Seventy-five percent reported favorable impressions of police contacts in cases of sexual assault. Seventy percent stated that either they "strongly encouraged" or "encouraged" patients to testify in cases of rape. The fear of being called to testify may be somewhat exaggerated as only 5% reported testifying more than once in a case of rape.[3] (See Appendix II-C.)

No procedures have been established in any community surveyed for either voluntary or required reporting to law enforcement agencies by doctors who treat rape victims. No state laws exist, as they do for treatment of gunshot wounds or suicide attempts, which require reporting to a law enforcement agency. We were unable to discover any program or formalized procedure to deal with the treatment of rape victims by private doctors.

Some private doctors work in hospitals with rape programs on a part-time basis, as in Pasadena's Huntington Memorial Hospital. By virtue of their affiliation, they may receive special training for the treatment of rape victims. However, there is no evidence that the procedures followed by the hospital are carried over into the doctor's private practice.

Information about private doctors who treat rape victims is found mostly in the area of follow-up treatment. Even in this area, information is limited to the fact that hospitals refer victims to private doctors in cases of necessary medical follow-up because few hospitals have outpatient facilities to provide these services.

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[3] Linda S. McGuire, *Physician Survey Report*, April 24, 1974.

Whether these victims actually seek out private doctors is not known.

5. *Health maintenance organizations.* Our few contacts with health maintenance organizations indicated that there were no special procedures adopted for the emergency treatment of rape victims.

B. Preexamination Procedures

Most programs treat a rape victim as one who has undergone a physical and emotional trauma. The physician assesses the victim's physical and emotional state and then administers treatment depending on the assessed priorities.

Some basic assumptions that these programs have made about the victim are that she needs immediate emotional support from whomever comes into contact with her and that she may need follow-up emotional support. These assumptions are probably valid, considering the number of authorities who have discussed the emotional trauma resulting from rape.[3]

Most programs have focused on the need for support; many have made this their only concentration. Comparatively few programs have attempted to change the attitudes of the police, doctors, prosecutors, and society toward rape victims. The most common approaches are "sensitivity training" and general educational programs for persons who come in contact with the victim.

1. *Initial contact with victim.* The need for support is considered most acute at the point of initial contact with the victim. Support functions include greeting the victim, putting her at ease, taking her to a more pleasant environment, explaining the procedures that are about to take place, contacting outside persons such as family members or rape counselors, and providing information. Depending on their training and purpose, the persons who make the initial contact may provide individual crisis counseling to the victim, general counseling concerning financial assistance and temporary housing facilities, and family counseling.

Several types of personnel have been used to perform any or all of these functions. They include nurses, social workers, rape crisis center volunteers, victim advocates, medical students, chaplains, and student chaplains. Some of these have been employed by the hospital; others have been volunteers from outside organizations or persons employed by outside agencies working in the hospital.

a. *Hospital personnel.* The full-time hospital personnel who usually perform intake support functions are the receptionist, who takes down basic information and then calls an emergency room nurse; emergency room nurses, who may perform the full gamut of initial counseling and explanation of procedures, as in Boston City Hospital; social workers, as at Harborview Medical Center in Seattle; psychologists; psychiatrists; or other mental health personnel.

Persons employed by the hospital, compared with volunteers, are usually more dependable, more accessible for training, and tend to have a greater impact on other hospital procedures because of their integral relationship to the day-to-day functioning of the hospital.

The use of such personnel depends on the cost to the hospital both financially and in staff hours. It is the initial commitment by the hospital that is the most difficult step in undertaking a program for the treatment of rape victims.

Once the commitment is made, one administrative problem with using regular full-time staff has been scheduling hours. At some hospitals, the full-time social worker only works the day shift. Since most rapes occur at night, the social worker usually is unavilable to the victim at the critical time and only gets to see her after the initial traumatic period has passed.

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[3] "Alleged Rape, An Invitational Symposium," *J. Reproductive Medicine*, Vol. 1[illegible] (1974): 133-152; R. J. Milliken, "The Sex Offender's Victim," *Federal Probation*, Vol. 14, No. 3 (Sept. 1950): 22-26; Ann Wolbert Burgess and Lynda Lytle Holmstrom, "The Rape Victim in the Emergency Ward," *Amer. J. Nursing*, Vol. 73, No. 10 (Oct. 1973); John MacDonald, *Rape: Offenders and Their Victims* (Springfield, Ill.: Charles C. Thomas, 1971); Menachem Amir, *Patterns of Forcible Rape* (Chicago: U. of Chicago Press, 1971); Sandra Sutherland Fox and Donald J. Scherl, "Patterns of Response Among Rape Victims," *Amer. J. Orthopsych.*, Vol. 40 (1970): 503-511; Joe B. Massey, Celso-Ramon Garcia, and John P. Emich, "Management of Sexually Assaulted Females," *Obst. and Gynec.*, Vol. 38 (1971): 29-36; and Ann Wolbert Burgess and Lynda Lytle Holmstrom, *Rape: Victims of Crises* (Bowie, Md.: Robert J. Brady Publishing Co., 1974).

b. *Volunteer assistants.* Volunteer assistants may be rape crisis center personnel, as in Philadelphia and Austin; community group rape support persons, such as participants in the NIP program at Mt. Sinai Hospital in Minneapolis or the YWCA rape victim advocates in Pasadena, who work with Huntington Memorial Hospital; student assistants, such as the University of Chicago female medical student volunteers; or the professors' wives and students at Stillwater Municipal Hospital in Oklahoma.

Several hospitals provide initial counseling and other victim support services by chaplains or student chaplains. An emergency room counseling program is a part of Clinical Pastoral Education, a nationwide training body for students in seminaries and theological schools. In Louisville, Kentucky, student chaplains are on 24-hour call at most area hospitals, including the large Louisville General Hospital. At Billings Hospital in Chicago, the program places a larger degree of responsibility on the chaplains. Their role is to help coordinate the rape victim's entire care, assessing her needs and planning the order in which services ought to occur, including the follow-up treatment and police involvement.

Two major problems with volunteers can be their lack of discipline and the inability of the hospital to use them effectively. Volunteers are usually less reliable at the intake stage than employed hospital workers, because they may be difficult to reach when needed or may not respond because of conflicting commitments. However, if the organization providing the volunteers is stable, the reliability of the volunteers has been found to be greater.

Another problem is that the system for contacting volunteers may be less than reliable, depending on home telephones, volunteers staffing a phone, or an answering service. Twenty-four-hour phone lines to volunteers have been set up to correct this potential breakdown in communication.

Yet, what volunteers lack in efficiency they more than make up in dedication. For example, rape crisis center volunteers usually have a philosophical commitment to their jobs and may well have a greater impact on the victim because of this. The medical student volunteers may add a dimension to their sensitivity, which may have a long-range impact on their future roles as physicians.

c. *Functions to be performed.* The victim who is brought to the hospital is usually confused, frightened, and either disinclined to make decisions or immobilized. Her immediate needs are to be made comfortable and to be informed about the procedures to take place. She should be asked about help she might need in becoming more comfortable, whether she wants friends or family informed, wishes to have volunteer assistance if available, whether she needs clothing or transportation, and whether she wants to report the crime to the police or is willing to have evidence taken which will not be released without her consent.

The Kansas City and Montogomery County, Maryland,[4] programs have recognized these needs and because of the disorientation of the victim provide written explanation of their procedures. (See Appendix II-D.) Care is taken not only to explain what will be done to the victim, but why.

Several of these procedures are optional, and thorough explanations help a victim make a more informed choice. Simple procedures, such as the police taking the victim's undergarments, or the unexplained presence of a photographer, are frightening and gross invasions of privacy to a victim who does not know that the clothing and photographs will be used for evidentiary purposes.

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[4] "What to Expect After the Attack" is available from the Montgomery Police Dept. Community Affairs Division, 60 Courthouse Square, Rockville, Md. 20850. (Requires stamped, self-addressed 6" X 6" envelope.)

Some functions that the initial contact person performs, such as the explanation of procedures, the distribution of information, contacting outside persons for assistance, referral to community resources for temporary housing facilities, and filling out forms, do not require any particular type of learned skill or sophisticated training, although an acute sensitivity to the victim is necessary.

Other functions—namely the triage (priority setting) function of a nurse—are not as readily performed without training. The triage nurse determines priorities for procedures in the emergency room. Volunteers can be trained to assist in all of these procedures, and the support function does not have to be a high cost item.

A major support function that requires more than minimal skills is crisis intervention counseling. In the District of Columbia and in Austin, Texas, social workers are trained to perform this function and believe it requires professional expertise. Yet, this is similar to the type of counseling that nonprofessional groups, such as the Philadelphia Rape Crisis Center advocates, perform for the victim. Whether or not professional training is needed is a subject of much discussion between rape crisis center persons and professional counselors. (See the Citizens' Action Handbook.)

Breckenridge Hospital in Austin, Texas, has attempted to resolve this conflict by providing social workers trained in trauma counseling to stay with victims throughout the initial hospital procedure and to coordinate with the community rape crisis center volunteers who provide escort assistance and back-up throughout the entire medical and legal process.

Personnel at the initial contact stage may begin to undertake some general counseling, as opposed to crisis counseling, and may make suggestions for long-term referral for both the victim and her family. It is at this stage that the professional versus nonprofessional controversy becomes more heated.

Assuming there is professional training, another potentially controversial area is the victim's preference for a counselor. When chaplains and student chaplains have been involved, some victims have expressed a positive reaction, others, a negative one.

Few hospitals are diligent in informing the victim of the necessity for and possible effects of medical procedures. Most hospitals say it is the doctor's responsibility to inform the victim of the medical tests and their effects. In fact, the doctor was found to be the staff person with the least time and inclination to do this, and few take the time. If it is done at all, it is usually done by specially trained nurses.

Even with procedures recognized as questionable, such as the use of DES as a prophylactic measure, many doctors do not inform the victim of its possible short- and long-term side effects, and some do not even offer the victim a choice in whether or not to undergo this treatment—they administer it routinely.

There appears to be no reason, except for an unusual medical situation in which a victim requires special medical treatment, to leave the explanation to a doctor. A well-informed trained person may perform this function at initial contact.

d. *Facilities prior to examination.* Hospitals treat a rape victim as an emergency case. Consequently, victims wait for treatment where other emergency victims wait, usually in a waiting room or the general lounge of the hospital. This situation has created problems for victims. First, there is little or no privacy for the victim, who may be escorted by a police officer. Next, the general frenzied activity associated with an emergency room adds to the confusion that may be affecting the victim. And, procedures in the emergency room may involve lengthy delays unless the priority system has determined that rape victims receive immediate treatment.[5] In some hospitals the wait may be up to four hours. Even in a hospital where only gunshot wounds, coronaries, and "severe emergencies" have priority over rape victims, the waiting time for treatment may be up to 40 minutes.

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[5] The "Summary of Data Gathered Regarding Counseling Rape Victims by the Chaplains' Department from February through October, 1974, Louisville General Hospital," indicated that the length of wait before medical examination was three hours for 4 victims, two hours for 11 victims, one hour for 11 victims, and less than one hour for 16 victims.

To eliminate some of these problems, some programs have victims wait in a semi-private room separate from but near the emergency room, or in a separate waiting room for rape victims. The internal medicine compound, not usually needed for other purposes at night when most rapes occur, is sometimes used. One hospital that uses the Ob-Gyn department waiting area also carries out medical examination in the Ob-Gyn treatment room, thus avoiding most of the emergency room problems.

In New Orleans, rape victims are examined by the coroner unless they have severe medical injuries, in which case they may either be treated first at the hospital and then taken to the coroner's office for the evidentiary exam, or treated and examined in the hospital.

e. *Police contact at medical facility.* If the victim is subject to an extensive wait before the medical examination, the police usually take advantage of this time to question her.

Whether a police officer should question the victim at length at the medical facility is in question, and some hospitals encourage the police to delay intense questioning until after the medical treatment, or until the next day.

Some programs try to eliminate the victim's possible embarrassment from being accompanied by a uniformed officer by having the police assign a plainclothes officer to the hospital to conduct questioning. Other hospitals have a resident police officer among whose duties is the job of reporting crimes and questioning victims. The reaction of the victim to a 24-hour resident officer can be negative because she may not wish to report the rape to the police, and because she may wish to remain anonymous to the hospital personnel and patients. An advantage, however, of a resident police officer may be that the officer can provide special expertise and sensitivity in the handling of victims of crimes, including rape victims.

Many hospitals require that police questioning be done in a room out of public view. A few hospital programs provide support personnel, either a nurse, social worker, or volunteer, to accompany the victim during questioning.

2. *Preliminary work-up*

a. *Consent forms.* After the initial contact with the victim, a preexamination work-up usually involves taking her medical history. This work-up is most often conducted by a nurse, although in Minnesota and Denver doctors perform the preliminary work up before they make the medical examination.

At this stage it is usual to obtain the consent of the victim to perform necessary medical tests and treatment and also to get her consent to release hospital records to the police for evidentiary purposes. Some hospitals ask for consent to photograph a victim and request estrogen therapy (DES) release forms. The consent forms are generally standardized as a part of the general emergency room forms. (See Appendix II-E for consent forms.)

The consent forms are rarely explained in detail to the victim. The understanding and signing of consent forms is treated as a legalistic procedure that merits little attention by the hospital or the victim. Boston City Hospital claims there have been no instances where a victim has not consented to the release of her records to the police. In some hospitals, the records are released to the police without obtaining the victim's consent.

b. *Report to police.* At the time the medical history is taken and consent forms are completed, if the victim has not been brought into the hospital by the police, she may be asked whether she intends to report the crime to the police. Whether a hospital should require reporting before it renders medical assistance is a controversial issue. Most hospital rape programs did not require the victim to report the crime before treatment. In fact, it is rarely mentioned unless a counselor chooses to discuss it with the victim.

However, at Denver General, it is hospital policy that medical examinations (as distinguished from treatment) will not be conducted unless the victim consents to report the crime to the police. In other locations, evidentiary examinations officially will not be conducted unless the police are informed, but medical treatment will be administered. Attending doctors have the option of conducting extensive evidentiary exams and evidence collection when the police have not been notified. Where a police officer on 24-hour duty reports the crime, this is tantamount to forcing the victim to report.

Some hospital programs (usually those working with rape crisis centers) try to allow the victim to make an informed choice on reporting after considering all the consequences. Some counseling groups, such as the University of Texas Psychological Counseling and Referral Center in Austin, and some rape crisis centers do not encourage women to prosecute.

C. The Medical Examination

1. *Protocol.* Most hospitals follow a set protocol for the treatment of rape victims, which is simply an outline of medical steps that must be followed by nurses and doctors. Protocols exist for most emergency room cases, and the treatment of rape victims is viewed as just another type of case. Protocols adopted by more sophisticated rape programs (See Attachment to Guidelines and Appendix II-F) reflect careful consideration of the victim's needs other than medical ones. They are aimed at insuring sensitivity by the attending personnel, as well as eliminating needless questions that could upset the victim. This type of protocol is usually the result of joint preparation by medical, community, counseling, police, and legal personnel.

Given the general stress of an emergency room situation, it is most difficult to develop a procedure that treats medical injuries properly, creates concern for the victim, assists in gathering evidence necessary for future prosecution, and is not too cumbersome for a doctor to follow. Few programs have achieved these goals in one protocol. The New York Health and Hospital Corporation spent much time in developing a protocol that doctors refused to use because it was too lengthy. Variations on this protocol are the "rape kits," which not only outline procedures but include all necessary equipment and tests for the examination. For those hospitals that use neither a special protocol nor a rape kit, the American College of Gynecologists and Obstetricians has developed a procedure for suspected rape that can be adopted in most hospitals (See Appendix II-G). The Southern California Hospital Association is preparing a protocol and other information on setting up rape victim procedures. In addition, the California Medical Association is in the process of preparing guidelines for physicians which set forth priorities for setting up an effective program.

2. *Personnel performing the examination.* The most comprehensive programs for the treatment of rape victims have used a team approach, considering doctors, nurses, mental health personnel, and consultant specialists as a unit, each with a specialized function. But the various personnel who deal with victims, considered independently, may vary in effectiveness.

a. *Doctors.* Medical doctors who perform the medical examination include coroners, interns, residents, medical officers, and private doctors.

When an emergency room is used for the examination, interns frequently perform the examinations, but their use presents several problems. Interns prefer not to perform rape examinations, because they do not consider that procedure to be a genuine part of their learning experience. In addition, because of the sporadic assignments to emergency rooms, interns rarely have enough experience in the treatment of rape victims to provide the emotional support that a victim needs during her examination. If the victim decides to prosecute, interns can be difficult to locate at the time of trial because their internship is usually completed. Thus, their testimony may be lost to a prosecutor. If they do testify as expert medical witnesses, their expertise can be challenged easily by defense attorneys because they lack experience in handling rape cases. Interns, as a result, are reluctant to testify.

Having recognized the problems with interns, the District of Columbia uses second-year residents to conduct examinations. The second-year residents have more experience, are more easily located for trial, and are not as prone to defense challenges to their expertise. However, a common problem with the use of residents is that many of them are foreign-born doctors who may possess language difficulties and cultural differences that have led to charges of insensitivity to rape victims.

For those hospitals that use the Ob-Gyn examining facilities, Ob-Gyn residents may be used. At Boston City Hospital and Dallas' Parkland Hospital an Ob-Gyn staff doctor is on call 24 hours a day to come to the emergency room to perform the examination. These doctors are presumably more skilled in rape examinations. However, obstetricians and gynecologists have been criticized for being insensitive to the fact that a rape victim, unlike women undergoing a routine pelvic examination, needs emotional support.

Smaller hospitals may have an arrangement to use a panel of private doctors for emergency situations, as in Berkeley, where the so-called Pontiac Plan is in effect. This arrangement has generated controversy in the medical community, as many doctors would prefer that full-time emergency room doctors handle these cases, rather than private doctors working part-time.

The role of the doctor in the treatment of rape victims has been subject to much criticism. In more than one community, doctors have been called the "weakest link" in the team of hospital personnel attending the rape victim because of a lack of sensitivity. In part this may be caused by their limited training in the emotional care and support of victims. Several communities have attempted to keep the doctor's role at a minimum and to concentrate on providing support through emergency room nurses and others who may participate on the treatment team and in some instances spend even more time with the victim.

However, at the University of Southern California Women's Hospital, the turnover rate for emergency room nurses and the problem of not knowing which nurse would be on duty have led to more reliance on doctors. In that community, doctors were preferred because they were thought to give much better explanations of the medical procedures. Yet, most other communities believed that doctors did not give adequate explanations.

The sex of the doctor did not appear to affect the victim's reaction to medical treatment. However, in all programs contacted, there were so few female doctors that the sampling is not scientifically informative. Most programs tried to sensitize all doctors—male and female—in hope that the sensitivity, and not the sex, of the doctor would put the patient at ease.

Several doctors noted that their medical school training had no emphasis on the care of victims of sexual assault. A few medical schools are taking steps to correct this.

b. *Nurses*. Generally the emergency room nurses have the most prolonged involvement with the treatment of rape victims. Because of this exposure, these nurses have chosen to be the instigators and lead figures in many programs, and they have become the trainers of other participants on the rape teams. Nurses view their role as a part of a team, whereas doctors tend to view their role in relationship to the patient more independently. Nurses explain procedures to the victim and perform some of the evidentiary tests, such as examination for bruises, pubic hair combings, and collection of extrinsic evidence. By forming a trusting relationship with the patient, the nurse can more effectively assess her needs for follow-up care.

Some programs, having recognized the need for possible specialized treatment, use a variety of physicians on a consultant basis according to the procedure that is diagnostically indicated. A psychiatrist may be called in for treatment for emotional trauma; if the medical situation warrants, a surgeon or radiologist may be called in; if a child is involved, a pediatrician might be on call.

3. *Scope of the medical examination.* The medical examination includes diagnosis of and treatment for any physical injuries. The part of the examination that involves evidentiary tests, both which tests and whether or not they should be performed, varies widely from program to program.[6]

The American College of Obstetricians and Gynecologists has issued a technical bulletin on procedure for suspected rape (Appendix II-G). It recommends taking these laboratory specimens for evidentiary purposes: acid phosphatase, blood group antigen of semen, precipeten tests against human sperm and blood, wet mount from fornil for examination for motile sperm, and culture for neisseria.

Many doctors who perform the evidentiary tests do not have a clear understanding of their law enforcement purposes. These doctors may be reluctant to make what they consider to be a legal judgment on a medical form. The incomplete forms are inappropriate as evidence in a courtroom, and doctors who may be called to testify find they are attacked on this basis.

Besides laboratory specimens, special tests or the gathering of extrinsic evidence may be required for law enforcement purposes. Few programs have established procedures to have the law enforcement officer make these special needs known to the hospital, and required evidence may be lost because of lack of communication. For example, pieces of grass from the victim's clothing might be a crucial fact in proving a case. But the doctor or nurse might miss their significance. Many of these tests may be performed by police crime labs, and require only a collection of evidence by the doctors, so the actual work required of the doctors is minimal.

Very few programs have coordinated with a law enforcement agency to decide which tests should be performed, either medical tests or those relating to extrinsic evidence. Kansas City's St. Luke's Hospital is developing a coordinated procedure for their staff, explaining police contact and prosecutorial functions. The few programs that have recognized a need for coordination with law enforcement agencies use medical forms that the doctors understand and complete. The prosecutors can use these same forms in court as evidence, with little need to call the doctor to testify.

Crucial to the selection of tests or treatment to be performed is the victim's role in making decisions regarding her own treatment. Some medication and treatment may be potentially injurious, but some hospital procedures provide neither explanation nor choice to the victim. The victim's participation, and proper counseling for medical treatment, are crucial factors in coordinating the procedures for medical tests.

4. *Chain of custody of evidence.* Once the evidence has been collected, it is imperative for proper admission as evidence in a court of law that the custody of the evidence be accounted for at all times from collection until admission. Few programs have addressed this postmedical procedure, but it is another crucial area that can severely hamper prosecution of a case.

Because there is no uniformity among hospitals or police departments about who performs certain evidentiary tests (i.e., the hospital or the police crime lab), evidence custody problems vary with the locale.

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[6] L. O. Barsegiants, "Examination of Semen and Saliva in a Single Stain," *Sudebno-Meditsinskaia Expertiza*, Vol. 14 (Oct./Dec. 1971): 30-32 (English Abstract); W. F. Enos, J. C. Bryce, and G. Mann, "The Medical Examination of Cases of Rape," *Forensic Sciences*, Vol. 17, No. 1 (January 1972): 50-56; L. R. Graves, Jr., "Medicolegal Aspects of Rape," *Medical Aspects of Human Sexuality* (April 1970): 109-117; and J. C. Rupp, "Sperm Survival and Prostatic Acid Phosphatase Activity in Victims," *Forensic Sciences*, Vol. 14, No. 2 (1969): 177-183.

Police being present in the examining room was found to occur in only very few instances. Where this procedure has been followed it is under the theory that the police must witness and maintain custody of the evidence. Happily, this practice is disappearing.

The most sophisticated treatment of the custody of evidence has been developed by Dallas's Institute for Forensic Science, a publicly supported crime laboratory. The institute has developed a Rape Kit and Form for the gathering of evidence. Once the evidence is gathered by the hospital according to the instructions, it is locked in a narcotics cabinet at the emergency room. When the tests are completed at the hospital, a person from the crime lab picks up the test results and teletypes the results to the police.

The majority of hospitals have not addressed the problem, and there has been little evidence of police-prosecutor-hospital discussion on this issue.

5. *Charges for the examination.* Adding insult to injury, the rape victim is more often than not charged for the examination. In public hospitals, if she cannot pay, the municipality or state bears the cost. Or, she is billed according to a sliding scale of charges based on her income. Private hospitals may charge a patient up to $70 for routine examinations for rape, although attempts are rarely made to collect if a victim does not pay.

Some states have adopted Victim Compensation Statutes designed to compensate victims of crime for their expenses. The statutes are too new to judge their impact on the medical costs of rape victims. However, many of them do not provide compensation below $100 damages. Medical tests are usually below this level, and rape victims rarely suffer more than this as financial damage. (See Appendix II-A for analysis of victim compensation statutes.) Private medical insurance and CHAMPUS benefits, if applicable at all, do not assist the poor. Several police departments pay for the costs of the examination if the victim chooses to report the rape, and one district attorney's office will bear the cost. However, the vast majority of rape victims are charged and are not reimbursed for their medical costs.

D. Follow-Up Treatment

The follow-up treatment of rape victims is the other major area focused on in rape programs. Little is known or documented about the aftereffects of rape. Existing follow-up programs reflect a shot-gun approach to finding the best answer. Follow-up can be divided into medical and counseling follow-up procedures.

1. *Medical follow-up.* Medical follow-up treatment may be required for some victims, depending on the type of injury that occurred. Approximately 63% of adult victims demonstrated signs of general physical trauma,[7] which may or may not require follow-up. If there are no apparent injuries, medical follow-up treatment is recommended as routine to check for venereal disease and possible pregnancy. Although some prophylactic measures may be given for venereal disease and pregnancy at the time of the initial examination, the treatment in other cases may be given at the follow-up stage, either because follow-up treatment is preferred to prevent overmedication at initial treatment, or because the physician recommends the follow-up as a second precautionary measure. (See Appendix II-H for form for medical follow-up.)

If pregnancy occurs or is anticipated, follow-up medical treatment may include abortion or a menstrual extraction. USC Women's Hospital is the recipient of a grant to conduct a menstrual extraction program, and there is no cost to the rape victim for such treatment. At the time of treatment victims are usually advised of facilities available for follow-up care, and of the need for it.

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[7] Burgess and Holmstrom, "Sexual Assault: Signs and Symptoms," paper delivered at American College of Emergency Physicians and Emergency Department Nurses Joint Scientific Assembly, Washington, D.C., November 4, 1974.

Few hospitals have facilities for regular outpatient follow-up care. The Seattle Sexual Assault Center at Harborview Hospital operates a special follow-up clinic. Some cities have follow-up clinics that provide a special time for the care of rape victims, for example, the Tucson, Arizona, County Health Department. St. Luke's Hospital in Kansas City and USC Women's Hospital have cooperative arrangements with area medical, mental health, and social services facilities. Rape victims seeking follow-up treatment at one of these facilities will be seen by special rape detail personnel.

More often, victims are referred to private physicians or public health facilities for medical care and venereal disease treatment. Victims may also seek care from free clinics, neighborhood clinics, university infirmaries, or health maintenance organizations.

The likelihood of a victim failing to receive medical follow-up care is great. First, the additional cost of medical care is discouraging. Next, the victim commonly goes through a denial stage and rarely wants to be reminded that she was raped. Finally, the continuity of care has been broken. If the same doctor or nurse could provide follow-up, some doctors believe the victim would be more likely to return. But facing new people and repeating the story is too painful a task for many victims.

No statistics are available on how many victims actually seek medical follow-up.[8] To counter the victim's disinclination to seek help, some hospital programs have assigned either a social worker, a counselor, or a public health nurse to contact the victim a few days after initial medical treatment to encourage her to seek follow-up assistance and to offer whatever assistance is available through the hospital.

2. *Counseling follow-up.* The majority of rape victim programs have focused on providing for the victim's emotional condition. The initial counseling provided at the hospital may consist of evaluation and assessment of the individual's problems and is usually of relatively short duration. Individual counseling, family counseling, and group therapy may also be recommended, on a short-term or long-term basis. (See Appendix IV-D for a discussion of the counselor's role with rape victims.)

Long-range counseling most often involves professionally trained persons, but it is usually expensive and difficult to obtain. In addition, most rape victims do not require psychiatric care. Also, psychiatrists do not necessarily have expertise tailored to rape victims.

Several hospitals have psychiatrists on the staff or available on a consulting basis to aid rape victims when diagnostically indicated. Some victims may go to private psychiatrists on an individual basis. Private psychiatrists are beginning to address the problem of rape as a matter of concern to their profession. Rape was the subject of two programs in California at the 1975 State Meeting of the American Psychiatric Association. Psychiatric care may be available at publicly funded mental health centers in larger urban areas. Psychiatric care offered through these mental health centers is a less expensive form of treatment than private care.

Social workers are in greater supply than psychiatrists, and they perform the bulk of counseling follow-up in rape programs. Many social workers are directly connected with a hospital and provide initial support and referral to outside agencies. The most popular approach has been to refer victims to outside agencies, such as Family Service, with social workers on their staffs. These agencies report that a high percentage of victims keeps the referral appointment.

About 20 organizations, including Planned Parenthood, Family Service, health clinics, schools, churches, neighborhood service groups, and health and welfare councils are developing counseling services for rape victims. (See the Citizen Action Section.)

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[8] The Violence Research Unit of the Northwest Denver Mental Health Center, Division of Psychiatric Services Department of Health and Hospitals, Denver, Colorado, has computed the sex assault cases seen at Denver General Hospital and referred to the Visiting Nurse Service during 1973. Of 229 cases referred, 135 victims were actually visited, and 8 victims refused service over the telephone. This service includes counseling follow-up as well as medical follow-up.

In some cities, hospitals refer victims to publicly funded mental health clinics for follow-up treatment by social workers. These clinics appear to be effective, and are certainly less expensive than private treatment. However, mental health facilities treat rape victims as only a small part of their caseload, and they have in the past evidenced little desire to develop this area of treatment.

Another popular design is for nurses (emergency nurses, psychiatric nurses, or visiting nurses) to provide referral and some counseling to victims. In other areas, a public health nurse makes telephone and home visits to victims as a part of the medical treatment and for emotional support. Sometimes the police make the contact with the public health nurse.

Chaplains may perform some follow-up counseling or may refer victims to outside agencies. Prosecutors and police detectives also may make some referrals in a well-coordinated program.

Much of the assistance available in the mental health area is in the form of volunteer, non-professional counselors. Rape crisis centers, specially trained volunteer groups, and students may all be available for special supportive follow-up services. The type of counseling provided is more limited than professional counseling, but it may be equally helpful, depending on the victim's needs. At the very least, volunteer groups can provide practical followup in the form of transportation to court or to mental health and treatment facilities and child care while the legal process and medical treatment are taking place. (See the Citizen Action Section.)

Many programs have recognized the need to reach out to rape victims to encourage them to use the services offered. Some programs intensify this aspect of support by having volunteers call victims during the two-week period after the rape. Public health nurses have reported that discreet telephone outreach to a victim is accepted and welcomed. If a victim clearly wants no help, the outreach is curtailed. In smaller communities, home visits to the victim are more possible than in larger communities where many rapes occur, although even larger community programs aim toward home visits as a good way to provide follow-up treatment. Most programs leave it to the victims to undertake the initiative for counseling followup, and limit their services to providing information to the victim.

E. Training

Most hospital rape programs pride themselves on their training sessions for personnel who deal with rape victims. These training sessions are mostly informational seminars explaining the medical procedures, with a "sensitivity training" segment that attempts to make the personnel aware of some of the general problems and emotional trauma of a victim.

1. *In-house training.* The most extensive training programs have been provided for emergency room personnel, primarily nurses, although doctors, social workers, and mental health personnel have been included. In Boston City Hospital, a nurse and a social worker have established regular workshops for training emergency room nurses. They concentrate on training psychiatric nurses to provide the initial contact and counseling with the victim. These same persons hope to institutionalize these training procedures by teaching a course in Victimology and Crisis Counseling at Boston College Nursing School.

Huntington Memorial Hospital in Pasadena has a broader program than crisis counseling and sensitivity training. As a part of their "Nursing Grand Rounds Conferences" for all hospital nurses, representatives of the police department, social service agencies, and emergency room department make presentations on the legal, medical, and emotional needs of rape victims. As a result of interest in these conferences, the hospital is developing a videotaped, two-hour training session devoted to rape crisis intervention counseling and to the medical and legal procedures. The use of the videotape as a training technique has been adopted by some hospitals to aid in training the high-turnover emergency room staff.

St. Luke's Hospital in Kansas City conducts two three-hour classes using a two-part slide show and tape presentation and a taped victim interview to sensitize all personnel to the procedures and problems endured by a rape victim.

A variation on the in-house training of staff by regular staff is found at St. Paul-Ramsey Hospital. There, the social workers and emergency room nurses receive "in-house" sensitivity training from regular staff, including doctors. They also receive some training from rape victims, representatives of the police department, and the SOS, an organization composed of professional agency representatives (including mental health agencies), which has developed a sensitivity training program for hospital emergency room personnel and social workers. D.C. General Hospital holds a three-session training program for all its staff, with participants from the prosecutor's office and the police. The first session deals with medical aspects of the treatment; the second handles the police and legal aspects; and the third is more general for all personnel. Billings Hospital in Chicago conducts clinical sessions on the treatment of rape victims for their emergency room staff. In New York, the Health and Hospital Corporation is designing a training program for emergency room personnel. The plan is to train a permanent staff of psychiatric nurses who will then train other emergency room personnel. The emphasis, again, is on sensitizing personnel to the needs of the victim. A problem in attempting to train *all* hospital personnel is that such a program becomes too cumbersome to be effective. Recognizing this, some hospitals train emergency room personnel and the head nurses from other departments.

Training doctors has been more difficult than training other personnel because the doctors feel they have merely a technician's role to perform—providing the medical examination. They also complain that they lack time to participate in such programs. Two hospital programs reported that physicians, if they attended sessions at all, would walk out. The most some doctors will do is review the protocol in a classroom setting. However, USC Women's Hospital reports that doctors have proven to be easier to train than nurses. That hospital conducts sensitivity seminars for Ob-Gyn and medical residents.

One way to solve the problem of physician's disinterest is to begin the training earlier, while the doctor is in medical school. The University of Southern California Medical School offers a regular course in sex offenses for second year students.

2. *Training in coordination with other agencies.* Some hospital programs use outside agencies to train the hospital staff. In addition, there are training programs for hospital personnel that are not organized or conducted at the hospital. For example, in Tucson the Public Health Department, the prosecutor's office, and the police department have formed a sex squad, consisting of a pathologist, a psychiatrist, and FBI specialists. They have held two, three-day seminars for more than 100 participants from police agencies across the state on "Rape Investigation" and "Child Molestation." These were not hospital programs, but the sex squad has begun a training program for the emergency room staffs of all five Tucson hospitals.

In Louisville, the student chaplains providing counseling for rape victims in the hospital are registered in the Department of Clinical Pastoral Education Training Program. The program consists of a minimum of 400 hours training in the basic needs of the rape victim and how the ministry can assist in meeting those needs.

In Berkeley, a psychiatrist who is a paid consultant to the police department teaches in the police recruit school. He uses the services of a rape victim and the prosecutor in his comprehensive discussions.

3. *Community education.* Although hospitals and law enforcement institutions are responsible for training their own staffs, a need to educate

the community in the problems of rape has been recognized in some localities. In Greenpoint Hospital in Brooklyn, the hospital's Community Advisory Board sponsored a rape forum to educate the community. This was the beginning of an aggressive campaign to prevent rape and improve the treatment of victims. The educational programs led to the formation of a Community Task Force on Alleged Rape and Sexual Assault.

F. Coordination with Other Institutions

1. *Police.* There are several points of contact between hospitals and the police which could create difficulty for the victim but, with proper coordination, could instead result in improved treatment.

The initial questioning of the victim by the police usually occurs near the scene of the crime. However, if the victim has not been questioned before being brought to the hospital, it is possible to make the initial questioning period easier. If the victim has her first contact with the police at the hospital, or if she has not been questioned earlier, some programs have a support person, such as a nurse, social worker, or community volunteer, stay with the victim throughout the questioning. The presence of someone "on the victim's side" is reassuring. The location of the interview has been a source of disturbance to victims. Some hospitals set aside a private room for the officer and victim, rather than have the questioning take place in or near public view. Finally, some arrangements have been made to assure privacy by having the questioning done by a plainclothes officer rather than a uniformed officer.

Police officers usually wait with the victim until the examination is completed. Sometimes the officers are to carry the acquired evidence back with them; sometimes their purpose is only to assure an escort home for the victim. During the examination, police officers are not allowed to be present, although in a few communities they do witness the examination.

One of the critical points of coordination with the police is most often neglected. Because one purpose of the examination is to gather evidence, it is imperative that doctors know what evidence is necessary for the police conducting the investigation. The hospital needs to know what tests it should conduct and what materials should be prepared for the crime labs if the community has such facilities. The police also should know the capability of evidentiary tests. Little coordination with police or prosecutors has been found in the development of hospital protocol.

As a part of the development of hospital protocol, the police should also assist the hospital in developing an efficient procedure protecting the custody of the evidence. The prosecutors are also vital to coordinating this procedure, since it is in a court of law that such a procedure may be challenged.

An area of coordination that has received some, but relatively little, attention is the role of the police and the hospital when a victim chooses not to report the crime to the police. One hospital program has arranged to send anonymous reports to the police so that an investigation might take place, and to provide information about when and where a crime occurred. Another practice in a few communities is the payment of costs by the police department for the tests and treatment of rape victims.

2. *Prosecutors.* Three major areas of coordination between hospitals and prosecutors' offices have been undertaken by rape programs.

The first is collaboration in the development of the hospital protocol and required evidentiary tests, noted earlier in the police coordination section.

The second area involves the development of continuing education for hospital staff and prosecutors. If doctors understood the needs and problems of the prosecutor's office more clearly, their reluctance to fill out forms might diminish. If prosecutors understood the doctor's difficulties in making what they consider to be "legal judgments," then prosecutors would have an easier time developing forms from which they can prosecute. The Queens, New York, Prosecutor's Office and the private hospitals in that area have appointed a liaison from each facility to solve such problems. It is only a beginning, and there is no comprehensive educational program as yet, but the two institutions are meeting.

The third area of coordination involves the need by prosecutors for doctors to testify as witnesses in rape cases. The overall problem is that doctors are reluctant to testify in court—so much so that they dislike examining rape victims because of the possibility that they may have to testify later. Doctors dislike testifying because the waiting time in court can mean long idle hours—a practice that has been corrected by some prosecutors who have put doctors on call or arranged their testimony at more convenient times. Doctors also do not like to testify because they are unsure exactly to what facts they are expected to testify, and they fear badgering by defense attorneys. Some hospital programs have arranged for prosecutors to explain the procedures to doctors as a part of a training program to familiarize them with the purposes and procedures of trial. Other prosecutors make it a point to take special time to prepare individual doctors for testifying. Basically, however, coordination between the two agencies does not exist in most programs.

3. *Citizen groups.* Because many hospital rape victim support program started as a result of community pressure, coordination between citizen groups and hospitals is further developed than is coordination with other institutions.

Coordination with citizen groups falls into three major areas. First, community groups provide volunteers for victim support services, either inside or outside the hospital. Community groups, such as rape crisis centers, have provided hospitals with volunteers for counseling and follow-up assistance. In one program, the rape crisis center is located within the hospital. Another group, YWCA, provides rape support and counseling in the hospital and, later, for follow-up treatment. Some hospital programs maintain a 24-hour hot-line during those periods when the rape crisis center lacks sufficient personnel to staff the line. One of the most common arrangements with community groups is for the hospital to distribute cards and inform victims about the availability of rape crisis centers or community groups. Finally, a few community groups have undertaken outreach functions to encourage nonreporting victims to seek medical attention.

A second area for coordination is the link between community education and education of the hospital staff. One hospital program has conducted community forums to educate the community about the problem of rape. The same program has a community advisory committee that has made the improved treatment of rape victims a priority item for the hospital and has sponsored bilingual community forums on rape. This type of program is a rarity, since most hospital policymakers have yet to recognize rape as a problem meriting special attention. Another variation on the community advisory committee, and a more common approach to coordination between community and hospital, is participation by community groups on a hospital task force designed to address the problem of rape. This usually leads to the participation of community groups or rape advocates in the education and training of hospital staff.

A third, and least developed, area of coordination is the use of community groups to provide outreach to victims who would not come to hospitals because of cultural, political, or financial reasons. The Pasadena Family Service Program, for example, uses minority neighborhood workers to encourage people to seek mental health assistance. Although encouraging rape victims to come in for treatment is not one of the functions of outreach workers, it is an approach some hospitals are considering. The Martin Luther King Neighborhood Health Center in New York uses neighborhood outreach workers to encourage low-income persons to seek medical assistance. The center also uses parent and teacher organizations to educate persons in the community. Such ideas have not been used to educate the community about rape. In fact, the entire area of outreach to minority victims has been virtually neglected.

4. *Public bodies.* Several hospital programs were initiated under the auspices or with the cooperation of municipal task forces or municipally sanctioned or assisted groups. The imprimatur of the city makes adoption by the hospital of a comprehensive program more likely. It tends to insure more effort to coordinate with other institutions, such as police and prosecutors, and involves other government agencies that can assist victims, such as mental health centers.

Many comprehensive hospital programs are found in areas where there are umbrella committees; for example, a women's task force on rape, research group, or community committee. These task forces for usually volunteer committees in which individuals from many professional backgrounds are pooled to seek some governmental assistance. Some of these task forces have had difficulty agreeing upon a specific course of action, because each agency has its own interest at heart and tends to want to dominate the entire program.

Because treatment of rape victims is a multifaceted problem and involves cooperation of individuals from many organizations and government agencies, some cities have set up umbrella committees to function as investigatory bodies to identify types of changes existing bodies need to improve the quality of care for the rape victim. In several cities such umbrella committees have been instrumental in planning training courses and implementing changes within their local hospitals. Some committees have drafted legislation, lobbied for programs, and publicized the problems of rape in the mass media. Spurred by state legislation, Minnesota and Massachusetts are creating state coordinating agencies to develop comprehensive rape programs. (See the Citizen Action Section.)

In the District of Columbia, the medical society has developed guidelines for the treatment of rape victims by private hospitals. The acceptance of such standards by the medical profession makes adoption by hospitals easier. Municipal task forces can affect public hospitals; medical societies can affect private hospitals. The logical next step is for medical societies to create guidelines for the treatment of rape victims by private doctors, in hope of reaching many victims who do not go to hospitals.

Another area for possible coordination is in hospital and university treatment programs. The psychological counseling component of the University of Texas (UT), at Austin Health Center is coordinated with the UT Volunteer Rape Crisis Center, which provides counseling and escort service to rape victims from the UT student population. However, the university program has had only limited contact with Breckenridge Hospital staff involved in the treatment and counseling of rape victims.

CHAPTER VI. GUIDELINES ON THE TREATMENT OF RAPE VICTIMS BY MEDICAL FACILITIES

A. Overview

Several basic observations should be made about any successful program to improve the treatment of rape victims. These will not be reiterated throughout the handbook, but they should receive consideration in program design and implementation.

- Any program designed by medical facilities for improved treatment of rape victims should, ideally, be part of a community-oriented approach. This requires a cooperative effort by police, prosecutor, citizen groups, and agencies that provide direct services to victims. If such a cooperative effort is formalized into a task force, consortium, or umbrella committee, it may be strengthened. Further, after changes begin, the Committee may want to take on permanent functions to insure progress and diligence by all agencies. If the municipal government or the mayor has been the moving force behind the effort, cooperation is more likely. However, the most significant factor is the understanding by each group involved that cooperation is essential for meaningful innovation.
- Participation in any aspect of the program should be at the victim's informed choice. She should be given every opportunity to make meaningful choices, and, if no choice exists, she should be told why. Obviously, each victim is different, and her needs will vary from case to case. However, all programs should respect her choice to the fullest possible degree.
- Although additional financial resources may make it easier to develop programs, and such programs may be more sophisticated, many aspects of an adequate response do not need additional funding. When innovative suggestions do require additional financial resources, consideration should be given to where funding can be secured. But lack of funding alone should not be an excuse for failing to make basic improvements that merely require internal organizational or procedural changes and increased efficiency.

B. Where Should Rape Victims be Taken?

The guidelines in this section are addressed more to municipal task forces and community-wide consortia than they are to individual hospital administrators. Obviously, the latter cannot, alone, effect the desired reforms.

1. *Community medical facilities.* Most major medical facilities in a community should be equipped to treat rape victims adequately. This should be the goal when a community initiates a program. Then a victim will have a choice of places to be taken for treatment. However, until this occurs, police or municipal authorities should make formal arrangements with a particular hospital or hospitals for the comprehensive treatment of rape victims.

At least one medical facility in the community should be available for the comprehensive treatment of rape victims. This facility should be recognized as such by both public and private sectors of the community and should work in cooperation with them. The police, in cases of reported rape, should be able to take the victim to the hospital of her choice, after explaining to her the kind of treatment she could expect to receive at the designated hospital. In order to select the medical facility to provide comprehensive treatment, consideration should be given to the following factors:

- The selection process should include representatives of the local medical society and hospital society.
- The hospital should have the capability of collecting evidence for law enforcement purposes.
- The facility should consider the financial need of a victim in determining cost.
- The facility should have research programs that might be helpful to rape victims.
- The facility should have adequate emergency facilities.

Other medical facilities should also be available for the treatment of rape victims, in addition to the comprehensive program at the designated hospital. These other hospitals clinics (ensuring reasonable geographic coverage) should at least have a protocol for the collection of evidence as well as the treatment of rape victims, whether or not special facilities or a program are available. The American College of Obstetricians and Gynecologists (ACOG) Procedure for Suspected Rape (Appendix II-G) may be simply adopted by all hospitals.

The police should have a readily available list of all the medical facilities, including clinics, available for the treatment of victims. This list should also include outreach medical facilities in suburban areas.

Private hospitals and private doctors should be encouraged to undertake local initiatives to develop programs and procedures for the treatment of rape victims. This could be done in conjunction with local medical societies, other social agencies, or the local or regional hospital association. (See Appendix II-B for D.C. Medical Society's suggestions.)

Further research is needed to determine how private doctors are treating rape victims; how many of these victims choose not to report the crime to the police; what private doctors' attitudes are toward the treatment of victims; and how this resource can be effectively rallied for improved treatment. At the very minimum, private hospitals and doctors should be encouraged to use the ACOG protocol in their treatment. Hospitals with existing rape projects or procedures should include special programs to make private doctors aware of the special problems of the rape victim.

In disadvantaged areas, it would be desirable if neighborhood health clinics could provide outreach workers to encourage rape victims to seek treatment. Because the priorities for treatment in these clinics do not usually include rape, other organizations should try to develop community awareness of the problem. Such organizations include parent groups, church groups, neighborhood organizations, nurse clinicians, social service agencies, and any health care provider.

Campus health centers and university clinics (as opposed to teaching hospitals) need to reexamine their attitudes and practices toward rape victims and the role of the university in improving the treatment of victims.

C. Preexamination Procedures

1. *Initial contact with victim.* The following procedures are general in nature. It should be emphasized, once more, that each victim is an individual, with her own special problem. Victims will evidence varying degrees of physical injury and emotional distress, and all procedures should be tailored to that fact. Some may not need all the help recommended in the next sections. Again, the victim's informed choice should be preserved whenever possible.

When a victim arrives at the medical facility, she usually is taken to a reception or triage desk, from which she is sent to a specified area for initial treatment. All personnel who staff the reception or triage desk should be informed of the special procedures for rape victims.

The victim preferably should be greeted in the specified area by a support person, who is a part of an interdisciplinary team that will treat the victim. Provided that adequate training is given in the special treatment of rape victims, this support person could be (1) a social worker trained in crisis counseling; (2) a nurse who is a stable member within the emergency room setting and who can be trained in trauma counseling; (3) a psychologist or psychology intern; (4) the community mental health worker; (5) a trained paraprofessional; or (6) specially trained volunteers, if the hospital does not have adequate funds for paid staff.

The initial support person should be able to perform many functions:

- Greeting the victim immediately.
- Notifying the appropriate doctor or confirming that notification has taken place.
- Asking the victim if she wants family or friends informed, and, if so, contacting them.
- Carefully explaining all procedures about to take place, including the purpose of the medical examination and the specific tests needed for gathering medical-legal evidence, the role of the police, the purpose of photographs, the purpose of consent forms, and the availability of follow-up facilities, including rape crisis centers and medical and emotional treatment facilities. It is important that the victim be given an opportunity to make an informed choice regarding all these subjects.
- Determining if it is practical for the physician, as part of the team, to explain the medical procedures, tests, and implications. However, a specially trained initial support person may perform these functions more inexpensively and is acceptable. Clearly, for specific questions about medical treatment that go beyond general information, the physician should be consulted.
- Providing the victim with a handbook explaining all of the procedures. If she has to wait, she can reinforce her understanding of what has been explained verbally to her.
- After explaining the purpose of consent forms, obtaining the necessary consents.
- Assessing the victim's behavior and functioning. The social worker, nurse, or counselor who performs this function must have adequate training in the psycho-social problems that rape victims and their families experience and should, after making the initial assessment, be prepared to refer the victim to other agencies or other team members for counseling.
- Arranging for a medical appointment for follow-up venereal disease detection. When possible, the victim should be phoned prior to the follow-up and reminded to attend.
- Asking the victim whether she needs clothing or transportation and making these arrangements for her.
- Providing other services, including information about making a report to the police or prosecutor and third-party reporting services (where the victim chooses not to report to the police directly, but instead makes an anonymous report to a third-party, who then conveys some information to the police).
- Maintaining a follow-up contact with the victim so that any late-manifesting psychological traumatic symptoms can be recognized.

Both professionally trained counselors and volunteers trained to deal with rape victims can provide information and assistance to each other, as well as to the victim. Neither group—professionals or volunteers—has a monopoly on the treatment of rape victims. The use of volunteers, of course, is less expensive. Properly trained volunteers know when it is necessary to call in a professional. However, to alleviate some of the problems that can arise when volunteers are used, a screening process might be developed and the following procedures considered:

- The biases of the volunteers should be known and discussed. For example, a volunteer from a rape crisis center that does not encourage rape victims to report the crime to the police should not violate the hospital's policy.

- The training of volunteers, whether done in the hospital or by an outside agency, should meet minimum standards outlined by the hospital. The hospital, in its selection procedures, should check each volunteer for compliance with such standards.
- The hospital should insure continuing supervision of the volunteers. If the supervisor works with a group of volunteers, she or he can obtain additional knowledge of their problems and solutions and transfer this knowledge to others in the group.
- The hospital should arrange for regular consultations between each volunteer and a permanent hospital member of the team for individual and group feedback.
- The reliability of each volunteer should be carefully examined, with the goal of avoiding undue turnover.
- Sex of the volunteer is not the first consideration. Sensitivity and experience count for more. If possible, the victim should have a choice between male and female support persons.

2. *Facilities and procedures prior to examination.* Rape victims should be treated as emergency cases, whenever possible. Even if the victim comes in a few days after the sexual assault, the traumatic nature of the occasion warrants some priority consideration. The victim should not be considered as a low-priority "walking ill" case.

A separate room is desirable as a waiting facility for rape victims. If a special room is unavailable, then under-utilized facilities or those available in the evening might be used. General emergency room waiting areas are not recommended. For victims who have delayed several days before seeking medical treatment, the emergency room may well be suitable.

Personnel on the interdisciplinary team should be scheduled on a 24-hour basis to provide coverage during the night hours, when most rapes occur.

A reliable system of 24-hour contact with volunteers should be established, with facilities for providing alternate volunteers whenever possible. In many communities, particularly small ones, the hospital or fire department emergency switchboards may be the best 24-hour ones available to accept calls and to contact volunteers. Answering services or a "hot line" that depend on volunteers must be checked to ensure reliability.

3. *Police contact at the medical facility.* If the police bring the victim to the hospital, it is most likely that they have already interviewed her. Preferably, in-depth questioning by police officers of the victim at the hospital should be discouraged. However, reasonable questioning of the victim (perhaps not requiring a formal statement) might save the victim a trip to the police department. Moreover, if the officers are supportive and helpful, some questioning at the hospital might even be therapeutic.

If questioning is necessary, it is preferable that it be conducted in a room away from the public. In addition, police officers waiting with the rape victim in a public area, unless they are in plain clothes, draw extra attention to the victim's plight.

Before she is questioned, the victim might be asked if she would like a support person with her during the questioning. The presence of a third party may create some problems at a later trial, however. The third party, for example, may be subpoenaed to testify about the victim's emotional condition, which could reflect on the victim's credibility in the courtroom. Still, we believe that as long as the hospital is alert to these potential problems, a support person should be with the victim if she desires.

If the victim has not reported the crime to the police, the support person or other initial counselor should inform her of the advantages and disadvantages of reporting to the police and of participating in prosecution of the rapist. The choice of whether or not to report the crime should remain with the victim, although she should be given an opportunity to have her family or husband participate in the decision.

In medical facilities where a police officer is present for security purposes, that officer should not interview the victim, unless he/she has been trained to work with rape victims; and after the victim has made her choice to report.

Whether or not the victim chooses to report the crime to the police, the hospital should provide medical treatment for her. Unless she objects, this treatment should include an evidentiary examination. The initial support person should explain why an evidentiary exam may be desirable, i.e., if the victim later changes her mind about reporting.

If victims choose not to report, the hospital, rather than the criminal justice system, becomes the entry point for treatment. It is, therefore, important that the hospital provide both medical and emotional assistance without necessitating police contact. For example, the hospital should consider having a 24-hour rape "hotline," or, in cities with a 911 emergency number, rape victims could be referred directly to the hospital rather than the police, if they choose. Additional sources of referral to the hospital could be the clergy or a system such as "Telemed," where the victim dials a phone number that plays a tape informing her of steps to take if she has been raped.

If the local police department is capable of utilizing the information, an anonymous (third-party) reporting system should be set up for victims who do not wish to report to the police, but do wish to make certain facts known about the assault. The hospital is not necessarily the institution to run such a system, but could coordinate with it through its counseling functions. Sometimes a victim will pursue prosecution of a case at a later date if it becomes known there are other victims of the same assailant who would be willing to testify. Such third-party reporting systems require extensive community education to make nonreporting rape victims aware of the system. (See the Police Handbook for its treatment of third-party reporting.)

Hospitals, with the assistance of the police and prosecutors, should develop procedures to preserve evidence for a reasonable period of time. This allows a victim to decide to report at a later date without endangering future prosecution.

4. *Consent forms and confidentiality*. As the victim goes through the medical treatment process, it is important that personnel who come into contact with her recognize the need to keep questions direct and to the point. She should not be asked repeatedly to describe what happened to her and forced to relive the experience again and again. The hospital must decide at the outset what information it needs to obtain, and what information must be released to outside persons. Where possible, the hospital should assign one person to gather this information—most probably, the initial support person.

Intrusion into the victim's privacy often goes even further than hospital questioning. The information obtained may be used at later times—in a court of law, in her school, and even in her own home. Because of the possible threat to her individual rights, the victim must be helped to understand what her consent to questioning and examination may mean for purposes of subsequent release of information.

Moreover, the medical facility should be aware of its possible liability for disclosure of confidential information about the victim to a body outside the hospital, such as the police or rape crisis centers. The trend of state legislation and recent case law is to extend tort liability for disclosure of information that is considered confidential has been broadened to include even the name of the victim and the fact that she has been raped. Further, even the practice of requiring a victim to report the crime to the police prior to treatment may expose the institution to tort liability for disclosure. Serious questions are raised about whether a victim can give a knowing waiver to her rights at any time coincident with the crime, or whether a reasonable period of time must pass before an intelligent waiver is possible. Because the laws vary in different jurisdictions, a hospital should review its possible liability with counsel before undertaking a generalized procedure for releasing information to an outside body.

The initial support person should carefully explain the importance and effect of the consent forms; a physician does not necessarily have to provide this explanation. Any problems concerning treatment the victim will receive should be explained to her so she can make an informed choice, including the option to accept some forms of treatment and refuse others. Then the consent forms authorizing the hospital to perform medical treatment become more meaningful.

It is possible that medical reports on the victim may be subpoenaed in the court process. Some information the hospital gathers for treatment purposes may be damaging to the victim in a courtroom, even though the information may not be relevant to the determination of whether rape was committed. For instance, if the victim has a history of venereal disease, or is a single woman using birth control pills, a defense attorney may single out such facts in an attempt to discredit her character.

To guard against abuse of the use of medical records, some hospitals keep a major medical record, a formal chart that includes the ongoing treatment of the patient, and a satellite record, which is not part of the formal chart but records information relating to such matters as venereal disease and abortions. These satellite records may be considered clinical notes. In some jurisdictions, both the major medical records and satellite records are subject to subpoena because they are not considered a formal part of the medical chart.

Consent forms authorizing release of medical records to the police or permitting photographs to be taken should be explained carefully so the victim can make an informed choice about making a police report. Other things that should be explained are, first, that one consequence of failure to report to the police and to release medical records might be that the victim becomes ineligible for reimbursement of expenses under a state victim's compensation law. Secondly, in hospitals with publicly funded research and data-gathering programs, care must be taken to protect the confidentiality of any victims who choose to participate in them. Reports requiring her name and medical information should be reviewed with the victim, and her permission should be obtained before such reports are forwarded.

D. Procedures for the Medical Examination

1. *Personnel performing the examination*. At the medical examination stage, the team approach to the treatment of the rape victim becomes most desirable. Ideally, the basic team for treatment has four constituents: the initial support person, such as a social worker or nurse; the physician, who is responsible for the medical aspect of the treatment; an emergency room nurse (this can be a dual role if the initial support person is a trained Emergency Room nurse), who may provide a supportive role to the victim as well as do part of the evidentiary examination for extrinsic evidence; and consultant members, such as a psychologist, psychiatrist, or mental health expert.

The physician performing the examination should have experience, skill, knowledge, and sensitivity and be available for possible later testimony. Any properly trained physician may conduct the examination, and collection of evidence should be part of the training of all physicians who might be expected to do it. Those in family practice are favored by some hospitals because they are more apt to recognize the implications of the rape for the victim's relatives and for her adjustment within the family. Emergency room doctors are preferred in some hospitals because of their experiences in trauma treatment. Gynecologists are the choice of other hospitals because they are more experienced in performing pelvic examinations.

It is important that the physician be available at a future date for possible trial. Second-year or other residents may well be used rather than interns because of the latter's lack of experience and the possible difficulty of locating them at the time of trial.

Foreign-born doctors may have some difficulty understanding cultural differences and language nuances, and, therefore, special training in handling rape victims may be desirable.

Nurses are key parts of the interdisciplinary team. Emergency room nurses have usually received trauma training and can perform counseling and supportive services for the victim, explaining procedures and creating a trusting relationship.

Nurses can do much of the evidentiary examination for extrinsic evidence, such as collection of grass, fingernail scrapings, etc.

In some states, a nurse may perform pelvic examinations as part of an initial screening process. She neither diagnoses nor prescribes, but refers all pathology to the physician. However, in some states this screening process might be considered unauthorized practice of medicine and, as such, would be illegal. Many states are beginning to train physician assistants to perform pelvic examinations, but this is also an area of questionable legality. Such practices should be checked in each state prior to assigning these functions.

2. *Facilities for examination.* Rape victims should be treated at facilities where the best comprehensive care can be given at one time. In rural or suburban areas without comprehensive facilities, consideration should be given to making rape kits and medical protocols available to private doctors and to smaller hospitals and clinics through groups such as the American Public Health Association or nursing and medical associations. Police departments in such areas can be asked to supply rape kits to patrol officers or investigating officers who, upon taking the victim to the hospital or clinic, can provide the staff with the necessary forms and materials for the examinations. If a victim chooses to go to a private doctor, the police also may be able to provide the kit to the physician.

Whenever possible, a victim should be examined in a separate examination room. An examining room in the Ob-Gyn department may be most desirable.

A shower and fresh clothing should be available for the victim immediately after the examination.

3. *Protocol.* A special protocol for rape victims should be in force at the medical facility. It should be direct, eliminate needless questions, and emphasize the individual responsibilities of each of the attending team members. For example, the protocol adopted by the Sexual Assault Center of Harborview Medical Center in Seattle is an excellent example of a protocol outlining specific duties of each team member. It is attached to this handbook and is recommended for use by other medical facilities because of its recognition of the need for sensitive treatment of the victim, its comprehensiveness, and its detail. It may not be suitable in its entirety for every hospital. For instance, Harborview uses a trained social worker as its initial support person. As noted, other types of trained support personnel are clearly acceptable. Still, the Harborview protocol is a fine example of the team approach to medical treatment. (Another protocol example, that of the U.S.C. Woman's Hospital in Los Angeles, will be found in the Appendixes.)

4. *Scope of the examination.* In determining what tests should be performed for evidentiary purposes, a cooperative effort should be undertaken by the hospital staff, the police, the prosecutors, and community groups. Because the laws vary from state to state on the legality of admitting certain evidence, police and prosecutors should consult with the hospital on the need and design of particular tests. Most medical-legal evidence that must be collected is designed to document trauma, determine the presence or absence of sperm and semen, and help identify the assailant.

Some controversy exists over the routine use of antibiotics for VD prevention and hormonal intervention (DES) for pregnancy prevention. A recommended procedure, when infection or pregnancy is not evident upon initial examination or culture, is to (1) explain all side effects of antibiotic therapy and morning-after therapy, (2) present the victim with the option of having the tests, (3) provide follow-up VD culture and pregnancy tests in approximately two weeks, (4) give the choice of antibiotic treatment after a definitive culture, and (5) consider the option of abortion should pregnancy occur despite therapy.

In communities with crime laboratories attached to the police department, a clear delineation should be made between tests the hospital should perform and those appropriate for the crime lab.

In most jurisdictions, hospital records can be admitted into evidence without the doctor having to testify. However, if the information on the forms is inadequate or ambiguous, the doctor may need to be called as a witness to explain the results of the tests he or she performed. Therefore, to avoid the necessity of doctors having to testify, forms that record test results should be simple, short, and adequate for admission as evidence in court.

All tests and procedures should be explained to the victim. If, after proper counseling, she prefers not to have a particular test, her choice should be respected.

5. *Chain of custody of evidence*. Local laws usually require that in order to introduce evidence in court, it must be shown that the evidence has not been tampered with between the time of its acquisition and its court admission. Consequently, hospitals should secure the evidence they have gathered until such time as the police or prosecutor need it. Local laws may differ on the requisite proof of security.

There is no necessity for police officers to watch the victim's examination under the guise of securing the evidence. A better method for protecting evidence is to immediately date, sign, and seal the evidence and lock it in a cabinet to which only specified persons (doctor, nurse, guard) have access. Arrangements should be made for the police officer to pick up the test results from the specified person and transport them immediately to the police department or the prosecutor.

6. *Financial costs of examination*. Although victim compensation laws have made inroads in alleviating some of the financial damage crime causes its victims, rape victims seem to be helped very little. Because of the unique nature of the crime—namely the evidentiary requirement of a medical examination, not necessarily related to her treatment—hospitals should consider obtaining public funds for at least this portion of the charge. Ideally, the victim should not have to bear the cost of any medical or counseling treatment reasonably related to the crime.

In jurisdictions where victim compensation laws do not cover the cost of any medical examination and treatment, the goal should be public payment of all costs reasonably related to the rape.

Hospitals should explore possibilities for reimbursement through local or state health or welfare departments.

When criminal justice agencies pay the costs of the examination directly to the hospital, payment is usually conditioned on the victim reporting the crime to the police. Criminal justice agencies should be encouraged to pay these costs; however, this payment should not be conditioned on the victim reporting the crime.

Public hospitals should not charge victims, or, at least, charges should be scaled to need.

Private hospitals should explore the possibility of having municipalities or state health or welfare departments reimburse the costs of the required examination.

If victims choose to go to private physicians for treatment or follow-up care, reimbursement may be available from the local or state health department or welfare department.

E. Follow-Up Treatment

Follow-up treatment for both medical and counseling purposes is an important part of assisting the rape victim. It is sometimes difficult, however, to obtain the victim's participation in follow-up treatment. She may prefer to be left alone because follow-up treatment may remind her of the nightmare she has tried to put in the past. A suggested procedure is to coordinate the follow-up with the victim's initial treatment, and, if possible and desired by the victim, to make such treatment part of a continuous hospital effort. The victim may be more likely to participate in follow-up treatment which deals with familiar faces. However, a number of follow-up choices should be available.

1. *Medical follow-up*. If the hospital provides medical follow-up treatment for victims as an out-patient service and as part of its comprehensive care, the initial support person should have the responsibility for making the follow-up appointment at the time of the initial examination. Here, again, the victim should not be forced to take treatment against her will. Her informed, considered choice should be respected.

The initial contact person should try to insure that the consenting victim does in fact follow up either at the hospital, at another referral facility, or with a private doctor. For instance, if appointments for pregnancy and venereal disease tests are made for her at the time of initial contact, a telephone call can be made a few days before to offer transportation or child care. This serves as a reminder and encouragement to keep the appointment when scheduled with the victim's approval. Home visits may also be appropriate.

2. *Counseling follow-up*. If crisis intervention is available at the hospital during the initial examination, a determination of the need for additional counseling can better be made. Should further intensive counseling be desirable, a psychiatrist or psychologist may be consulted. If the psychiatrist or psychologist is part of the hospital staff, greater continuity of support assistance may be more likely. (See the appendix on counseling to the Citizen Action Section.)

Facilities that do not have a mental health staff should refer victims needing such services to outside agencies properly staffed with counselors. Again, care should be taken to coordinate this follow-up counseling with the initial treatment.

Victims ought to have a choice of whether or not to obtain counseling. They should be given the names and phone numbers of agencies that offer services for rape victims.

Most often, the initiative of encouraging a victim to obtain follow-up counseling is properly taken by the hospital or its affiliated personnel. The initial support person at the hospital or a public health or visiting nurse should use follow-up telephone calls or home visits to suggest that victims take advantage of available counseling facilities.

With the victim's consent, the police department might coordinate with the hospital or follow-up facility by making police reports of rapes available to the health or counseling facility. Victims who have not sought medical treatment, but have reported the crime to the police, then, might be contacted by telephone to inform them of available counseling facilities. Public health personnel, visiting nurses, or victim support persons can perform this function.

F. Training

Training should be a continuing process of supplying new information about procedures to persons assisting rape victims. Training may be designed to upgrade the performance of personnel within the hospital and to improve medical procedures through coordination with other institutions, such as the police and prosecutors.

1. *Professional training for hospital personnel*. All personnel assisting rape victims should receive training sensitizing them to the victims' needs. Personnel should also fully understand all rape treatment procedures in their own facility.

Such training, ideally, should be incorporated in the curricula of professional schools. Medical schools and professional schools, such as nursing and social work, should provide instruction on the care of victims of sexual assault. Students in the health professions might serve as volunteers at the hospitals during relevant course assignments.

A course should be developed at the hospital to help train attending personnel—doctors, nurses, social workers, support persons, and volunteers. Training materials ought to contain a thorough explanation of medical processes, legal and evidentiary requirements, and police procedures. Training to acquaint personnel with the particular emotional needs of the rape victim should also be provided. Videotapes, slides or cassettes could be used to record the training sessions so that new personnel has access to training materials on a regular basis.

Preferably, training materials should be jointly developed by nurses, victim support persons, and doctors. The participation of knowledgeable outside agencies, including police, prosecutors, mental health agencies, rape crisis centers, and counseling groups, ought to be welcomed in the development of training curricula and in the actual teaching.

In communities with several hospitals, a municipal task force or a community coordinating group might well be organized to develop and conduct training at all area medical facilities.

Professional associations, physicians, nurses, social workers, psychologists, and psychiatrists should be encouraged to develop complementary special training programs for the treatment of rape victims.

2. *Coordinated training*. Police departments and prosecutors should be asked to participate in training with hospital personnel. One suggestion is to develop this approach under the auspices of an overall coordinating body. Such a coordinating group can plan and implement training courses for all institutional participants and may have the resources to provide for research in key areas.

Community groups with an interest in rape, such as rape crisis centers, also should be encouraged to join cooperative training programs with other institutional personnel.

Hospitals ought to consider forming an advisory committee to supply continuing evaluation of their own policies for treating rape victims. Such an advisory committee could well have representatives of other community groups and institutions on its board. Also, it could meet with groups of health professionals, such as the American Medical Association and the American Hospital Association.

3. *Community education*. Community education concerning the problems of rape is a task best performed by a coordinated effort of all groups and institutions assisting rape victims. Hospitals can undertake special programs for the education of the community in their unique areas of expertise.

Hospitals ought to think about establishing educational forums particularly directed at minority groups. In communities with community action programs or other social agencies that use neighborhood workers, hospitals can coordinate with these organizations and use the neighborhood workers to encourage rape victims to seek medical and counseling assistance. Of course, if a hospital can afford to hire its own minority group neighborhood workers to perform these functions, this would be ideal.

The use of neighborhood workers is especially appropriate in those poverty areas where victims have become alienated from law enforcement authorities. If the neighborhood workers are bilingual, victims who are reluctant to seek assistance because of cultural and language differences may be reached more easily. Educational programs, thus, can focus on developing alternative systems of treatment for such victims, whether or not they choose to become involved in the criminal justice system.

G. Coordination

Many aspects of medical facility coordination with other local agencies and groups have already been discussed. Rather than repeat the material, this section will simply refer to specific types of coordination. As noted, the overall community response to the treatment of rape victims will be enhanced by a cooperative effort among the police, prosecutors, and community groups providing services to the victim.

1. *Police*. Medical facilities should work closely with the police particularly in the areas of police reporting and interviewing at the hospital, developing a medical protocol, ensuring an unbroken chain of custody of evidence, and in cooperative training.

2. *Prosecutors*. Coordination of the medical facilities with the prosecutor's office is especially important in such areas as the development of a medical protocol and the scope of examinations for extrinsic evidence, securing the chain of custody of evidence, and in joint training programs.

In addition, it would be helpful if prosecutors could arrange to put doctors and hospital personnel on call to testify in court rather than have them wait for several hours at a time. Where state law allows, prosecutors might preserve the testimony of doctors and hospital personnel through use of depositions to be used as evidence in the later trial.

Prosecutors should assist in developing and explaining all required forms to doctors. This explanation should include how such forms relate to the legal process, to what facts doctors will be expected to testify at trial, and such alternatives as keeping a satellite record.

3. *Citizen groups*. Cooperation with citizen groups can be most productive. Medical facilities should be alert to the fact that such groups can often provide victim support personnel, help develop medical protocols, assist in follow-up counseling, participate in coordinated training, and initiate community education programs.

4. *Public bodies*. Medical facilities are urged to take the lead in forming coordinating bodies (preferably with the imprimatur of city officials) composed of police, prosecutors, hospitals, citizen groups, and representatives of public and mental health agencies. Members of such a coordinating body could draft necessary legislation, urge needed reforms, and provide publicity and information about rape matters to the public. The coordinating body should establish goals for each institution's handling of rape victims within the context of a workable, comprehensive policy.

Community groups and institutions could recommend reforms to state agencies, which, in turn, could establish a state coordinating body perhaps with funds for local communities to develop comprehensive and coordinated rape programs.

ATTACHMENT TO GUIDELINES ON THE TREATMENT OF RAPE VICTIMS BY MEDICAL FACILITIES

PROTOCOL FOR THE SEXUAL ASSAULT CENTER
HARBORVIEW MEDICAL CENTER, SEATTLE, WASHINGTON

(Reprinted with permission of the Harborview Medical Center.)

GENERAL: INFORMATION FOR ALL INVOLVED WITH PATIENT

1. SEE IMMEDIATELY - even though no severe physical trauma may be present, sexual assault victims should receive priority in triage.

2. PROVIDE MAXIMUM EMOTIONAL SUPPORT - all efforts should be made to minimize additional emotional trauma.

3. REMEMBER - at all times it is our function NOT to be moralistic, but to provide such care both emotionally and medically as needed.

4. DO NOT DISCUSS sexual assault cases with anyone without specific victim consent.

5. "RAPE" and "SEXUAL ASSAULT" ARE LEGAL TERMS - not medical diagnoses. Do not use other than as "history of sexual assault."

6. THE CHART MAY BECOME LEGAL EVIDENCE - be sure that all statements are objective, accurate, and legible.

EMERGENCY ROOM PERSONNEL:

1. SIGN the victim into the Emergency Room.

2. CONTACT ER PHYSICIAN IMMEDIATELY, if evidence of moderate to severe trauma.

3. CONTACT SOCIAL WORKER IMMEDIATELY.

4. PROVIDE private facilities for the victim. Do not have the victim undress until just before the examination.

5. If the assult occurred within the past 48 hours, CONTACT PEDIATRIC RESIDENT (for victims 16 years or younger) or first available ER RESIDENT (for victims older than 16.) If the assault occurred more than 48 hours previously, the social

worker will evaluate and either give the victim an appointment to the next available clinic or will request physician consultation earlier, as needed.

6. Place Sexual Assault kit and vaginal set in examination room. Check and replace used items daily.

7. Chaperone pelvic exam.

SOCIAL WORKER:

1. See victim as soon as possible; reassure and comfort as indicated.

2. Confirm that appropriate physician has been notified.

3. Determine who brought or referred victim; speak with escort if possible; record.

4. Inform victim about medical examination, tests, possible medication, and the need for medical-legal information to be gathered.

5. Obtain consents for: examination (including pelvic, medical, and medical legal); photographs; release of information (specifically if it is to be given to police). Parent or guardian consent is necessary if victim is a minor. Consider court or Children's Protective Service intervention if needed to facilitate consent.

6. Assess victim behavior and functioning. Minimize interrogative aspects. Allow victim to verbalize as she wishes. The victim may have a need to relate feelings and the facts regarding the assault before some of the above matters are considered; BE FLEXIBLE. The victim may not want to share some of these facts initially; respect these wishes. The social worker/counselor/nurse who gives service to the victim should have adequate training re: the psycho-social problems that rape victims and their families experience. Obtain, as possible;

    a. Social history surrounding assault: when, where, by whom, in what manner (vaginal, oral, anal)? With what threat? When, how and from whom did victim seek assistance afterwards? What is the plan for reporting to police or Third Party reporting?

    b. Impression of present functioning - describe behavior and affect. Ascertain support system (familial, peer, professional). Document anticipated reactions, changes, and impressions.

7. When physician arrives, present history and impression in consultation. If the physician is present at the time victim gives the history, the physician should participate. DO NOT ask victim to repeat the history. Determine whether the social worker's presence is needed during the physician's examination.

8. If the victim desires, and if not previously done, the police may be contacted to come to the Emergency Room, day or night, to obtain a report and collect evidence (clothing, acid phosphatase, photographs, etc.).

9. For photographs (if physical trauma is evident) contact the hospital photographer or use the Polaroid camera available in the ER sexual assault kit. Two copies of the photos are needed (one for the chart and one for the police); social worker operates the Polaroid.

10. When the work-up is completed, give the victim a medical follow-up appointment in one week, information sheet, and VDRL requisition (explain need for follow-up VDRL in eight weeks).

11. Arrange for an escort home as needed. Arrange temporary housing if needed. Record planned or anticipated change in housing.

12. Record as plan, social services offered to the victim:

    a. Ongoing counseling: individual, group, family (siblings, parents, couples); via office or home visits.

    b. Referral or consultation with social or law enforcement agencies.

    c. Volunteer services (advocacy, third party reporting, interim housing).

13. All pediatric age victims must have referral (note) to Pediatric Social Worker for follow-up and possible Children's Protective Services referral.

PHYSICIAN:

1. RESPOND PROMPTLY - ascertain history from social worker and corroborate pertinent data with the victim. Obtain history conjointly with the social worker when feasible.

2. Obtain directed medical history. Use History of Sexual Assault form available in ER. Specifically ask about:

   a. Menstrual, contraceptive, coital and VD history and activity post assault (changes of clothing, bathing, douching, etc.);

   b. Pertinent medical history;

   c. Ascertain wishes regarding hormonal pregnancy prevention, abortion and menstrual extraction.

3. PERFORM PHYSICAL EXAM - with hospital employee as chaperone.

   a. General: include emotional status, general appearance of victim and clothing; document areas of obvious trauma;

   b. Specific: examine areas involved in sexual assault, e.g., genital, oral, anal. Document carefully evidence of trauma of these areas. (In the absence of vaginal trauma, in pediatric and younger frightened victims, a complete pelvic exam is unnecessary. Specimens may be obtained with sterile pipette, obviating use of stirrups, specula, etc.);

   c. Obtain photographs as indicated.

4. Obtain Medical Tests:

   a. Culture body orifices involved for Gonorrhea, e.g., endocervix, mouth, rectum; for pediatric patients, culture vagina;

   b. Baseline VDRL;

   c. Gravindex as indicated; especially if there is some question victim may be pregnant.

5. OBTAIN LEGAL TESTS:

   a. Ultra-violet lamp (Woods lamp) will cause semen to flouresce (even after vasectomy) and will indicate areas on the body or clothing for further exam. Use in the dark after visual adaptation.

b. Obtain specimens for sperm from body areas involved. Aspirated specimens are preferable to cotton swabs.

> WET MOUNT PREPARATION - drop of secretions ± drop of saline. Examine five minutes under hpf. DOCUMENT PRESENCE OR ABSENCE and number of motile/non-motile sperm.

c. Collect specimens for acid phosphatase determination from areas of flourescence or involvement. Place aspirated or scraped specimen in capped labeled tube. Submit to police, if indicated (i.e., if no sperm found).

d. Permanent smear of secretions from involved areas. PAP smear is best, but methylene blue or gram stain may be used. Ask Pathologist to document presence or absence of sperm.

e. Further tests to document identity of offender as police request: scrapings from beneath fingernails, secretions for ABO antigens, etc.

6. Treatment:

a. Injuries as indicated; if genital injuries are extensive or if the victim is an apprehensive child or younger adult, the repair should be under general anesthesia. Appropriate consultation to other services as indicated.

    1. Give Tetanus Toxoid if clean minor wounds are present and the victim has had prior full immunization with last booster more than five years ago.

    2. See Public Health recommendations for Tetanus Toxoid (available in ER) in other situations.

b. Pregnancy prophylaxis if victim is menarchal, is using no contraception, and is at risk in her cycle.

    1. Hormonal Therapy - Ethinyl Estradiol (Estinyl) 2.5 mg BID for 5 days or Stilbestrol 25 mg BID for 5 days. Mention side effects and efficacy.

        2. Antinauseant Therapy - Bendectin (ii HS as needed for nausea and vomiting) should be given patients routinely to use as needed.

        3. The victim should be informed that taking estrogens may result in increased risk to fetus if pregnancy follows and should be assured that if she misses a menstrual period in spite of therapy, or fails to have withdrawal bleeding from estrogens, menstrual extraction or abortion can be performed.

    c. VD prophylaxis - given as indicated (e.g. multiple rapists, but not routinely):

        1. Probenecid 1 gm orally + Ampicillin 3.5 gm stat orally; or

        2. Probenecid 1 gm orally followed in 30 minutes with Procaine Penicilline G 4.8 million units IM; or

        3. If penicillin allergy, Spectinomycin 4 gm IM, or Tetracycline 1.5 gm stat and 500 gm q.i.d. for 4 days therapy may be substituted.

7. Final Diagnosis:

    a. History of Sexual Assault;

    b. Document presence or absence of sperm;

    c. Make specific diagnoses of trauma: contusions, lacerations, etc.;

    d. Other pertinent medical diagnoses.

8. Follow-up:

    a. Appointment to Gynecology or Pediatric Clinic in one week;

    b. Repeat GC cultures at follow-up visit, further tests as necessary;

c. Repeat VDRL in eight weeks;

d. Request consultation from Pediatrics, Gynecology or Psychiatry initially or in follow-up as indicated.

SECTION 3

THE RESPONSE OF PROSECUTORS' OFFICES*

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*Research performed by Legal Resources, Inc., Washington, D.C.

CHAPTER VII. INTRODUCTION

Considering the alarming increase in reported rapes and the continuing low conviction rate of alleged rapists, prosecutors have ample reason for concern. Prosecutors' offices realize the pernicious nature of rape. Yet, for the most part, rape cases are not handled differently from other, less sensitive crimes. A few prosecutors' offices, however, have begun to come to grips with the problem. Many more have indicated a desire to do so.

In response to growing citizen criticism and the concern of a few forward-looking prosecutors, some prosecutors' offices have developed programs attempting to improve their handling of rape cases and their treatment of the rape victim. Innovations in the response of prosecutors' offices to rape, which were found either developing or in use during the summer and fall of 1974, are summarized here.

The guidelines that follow are based primarily upon the results of a national survey of prosecutors' offices with progressive programs conducted by Legal Resources, Inc. In addition, however, they incorporate substantial amounts of information and advice provided by a panel of prosecutor personnel and community persons, as well as by a number of rape victims themselves.

Almost all the programs examined are new, and few absolute conclusions can be drawn from them at this time. This has not been a scientific, empirical study of the programs; rather the findings are reportorial, with the hope that more can be learned over a longer period of time. It should be remembered that while concern for the victim permeates this discussion, this concern, of course, must be exercised within constitutional due process consideration for the rights of the defendant.

During the spring of 1974, to locate those prosecutors' offices taking an innovative approach to rape cases, a search was made of legal journals, court management writings, women's literature, and national press and media coverage. Ads were placed in relevant journals and magazines, and LEAA headquarters and regional personnel were contacted, as were representatives of the National District Attorney's Association and the National Center for Prosecution Management. Valuable contacts were supplied by persons in those programs known to have developed or to be in the process of initiating innovative programs, and by rape and court management conferences in Washington, Atlanta, and Kansas City in the spring of 1974. Colleagues in the police, medical facility, and citizen action units were also asking local contacts for names of key prosecutors' offices.

From all of these sources grew a list of 41 promising leads—many of which also suggested additional contacts. By means of a standardized telephone checklist questionnaire, each of these sources was surveyed as to type of office; kind of legal and nonlegal personnel used; procedural courtroom modifications; special training conducted for personnel; and coordination with community groups, police, and medical facilities dealing with rape victims.

Based on the response to this telephone survey, 18 prosecutors' offices with some special feature were selected for more intensive examination through on-site visits. A standardized questionnaire was administered to personnel in each of these 18 programs, seeking to refine and expand the information first obtained in the telephone survey. This procedure and the questionnaires involved were site-tested in a pilot visit to Philadelphia. Visits to prosecutors' offices were usually made by only one staff member, who ordinarily spent about one day with prosecutor personnel and, perhaps, another day talking with other interested and knowledgeable persons in the community. The preponderance of the following information is based on the project's 1974 survey and site visits. However, some information collected in 1975 has also been included in the findings.

Prosecutors' Offices Surveyed

Akron, Ohio
Ann Arbor, Michigan
*Atlanta, Georgia
Austin, Texas
Baltimore, Maryland
*Bronx, New York
*Brooklyn, New York
Champaign, Illinois
*Chapel Hill, North Carolina
Chicago, Illinois
Cincinnati, Ohio
Cleveland, Ohio
Dallas, Texas
Dayton, Ohio
*Denver, Colorado
*District of Columbia
Ft. Lauderdale, Florida
Houston, Texas
Indianapolis, Indiana
Jackson County, Florida
*Kansas City, Kansas
*Kansas City, Missouri
*Los Angeles, California
*Manhattan, New York
*Milwaukee, Wisconsin
*Minneapolis, Minnesota
*Nassau County, New York
New Orleans, Louisiana
Oakland, California
Omaha, Nebraska
*Philadelphia, Pennsylvania
Pittsburgh, Pennsylvania
*Portland, Oregon
Prince George's County, Maryland
*Queens, New York
Rochester, New York
San Diego, California
*San Francisco, California
*Seattle, Washington
Spokane, Washington
Tucson, Arizona

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*Denotes Site Visit

CHAPTER VIII. FINDINGS ON THE MANAGEMENT OF RAPE CASES BY PROSECUTORS' OFFICES

A. Courts and Criminal Procedure

Because most prosecutors' offices are organized along the structural lines of the courts and court procedures in criminal cases, a brief introduction to these subjects is warranted.

1. *Court systems.* Court organization follows political jurisdictional boundary lines. Virtually all rape cases arise under state laws. State criminal courts are generally organized on a county basis. Usually, large cities, within counties, have their own municipal courts. In many cities and counties, the lowest criminal court or division has jurisdiction only over misdemeanors. Felonies, such as rape, are heard at the next highest criminal court level. Often, however, the lowest court, in addition to handling misdemeanors, also disposes of such preliminary matters in felony cases as the presentment, preliminary hearing, and arraignment; but the next level court conducts the actual felony trial. In all felony cases, appeals may be taken to a secondary or tertiary level state appellate court.

2. *Criminal procedure.* While criminal procedure obviously varies from state to state and county to county, there are usually five important steps involving the rape defendant, the prosecutor's office, and, sometimes, the victim. Soon after arrest and filing of charges, the defendant has a presentment hearing before a magistrate or judge when bail may be set and the defendant advised of his right to counsel and of the nature of the charges against him. The second step is usually a preliminary hearing, when the same or another magistrate or judge must determine whether there is probable cause to believe that (1) a crime has been committed and that (2) the defendant committed it. Either alternatively or subsequently, the third step may be a grand jury proceeding where probable cause again is determined, and an indictment against the defendant is or is not returned. However, in many jurisdictions, there are no grand jury proceedings in matters such as rape. Assuming probable cause is found, either at the preliminary hearing, by the grand jury, or both, the usual next step is the arraignment, where a defendant enters a plea of guilty or not guilty. If the case is not previously disposed of, a trial then ensues. Throughout this whole process, and especially between arraignment and trial, intensive plea bargaining may go on between the defendant and the prosecutor's office, aimed at dismissing the charges or pleading to a lesser offense.

B. Organization of Prosecutors' Offices

1. *Staffing Patterns.* The staffing patterns of prosecutors' offices are influenced most strongly by the size of the office, whether located in an urban or rural area, and the structure of the area's criminal justice system. Larger urban offices possess the greatest flexibility.

a. *Large offices.* Almost invariably, prosecutors' offices in moderate to large urban areas are subdivided into functional operating units. These separate units usually handle (1) filing of complaints ("papering"), (2) preliminary hearing, (3) grand jury, and (4) trial. In the larger offices, the trial section may be subdivided still further into misdemeanor and felony sections. Typically, this means at least four and possibly five prosecutors will meet with, scrutinize, and question the complainant (victim).

In addition, a number of the larger offices have created substantive units to prosecute certain crimes, such as major frauds, homicides, narcotics, and sex offenses. Some of these substantive units will take the case at complaint filing and follow it through to final disposition.

In another variation, the unit handles only a certain type of crime once the proceedings reach the trial stage. There are few rape or sex crime units of this type, although by practice in some jurisdictions (as in the Bronx), rape trials are handled by a few designated attorneys. More common, however, are major crimes sections, as in the District of Columbia, where rape, homicide, and burglary are grouped together and handled at the trial level by a separate substantive trial unit.

In the typical prosecutor's office, organized along functional lines, the most junior attorneys are placed in the complaints section, the next senior in the preliminary hearing unit, and so on until the trial section is reached, which usually contains the most experienced prosecutors. Thus, the least experienced attorney is usually the first prosecutor to come into contact with the rape victim. Exceptions are found in St. Paul, where the charging attorney is the highest of four levels, and in Manhattan and Seattle, where complaints are handled on a rotational basis. In most cases, the victim is called upon to narrate her story at least three or four times to different prosecutors and, then, possibly as many times in open court.

In Kansas City, Missouri, however, when a rape is reported, the police detective contacts an assistant prosecutor, who comes to the police station and takes the formal history jointly with the police. This individual stays with the case until final disposition and either tries it or assists at the trial.

Other offices are divided into units corresponding to court organization. Typically, one court, and, therefore, one unit of the prosecutor's office, is responsible for all misdemeanors and preliminary matters in felony cases. A second court, and second unit of the prosecutor's office, deals with felony trials. In such situations, rape complainants would generally come into contact with at least two or more attorneys.

In some jurisdictions, matters are made even worse for the victim by the pool calendaring system under which cases are assigned to prosecutors only days before the actual trial on the basis of the calendars of the attorneys in the trial pool. And in others, attorneys are assigned to cover specific courtrooms, so that assignments are not made until after the case has been scheduled for a given court.

b. *Small offices.* There is also great diversity in the staffing patterns of smaller offices. An office that serves a relatively large geographical, but low population density area, may be organized by county, with different attorneys handling cases arising out of designated geographical areas. Under this type of organization, a given case is usually handled by one attorney all the way through prosecution.

In relatively small cities, the prosecutor's office generally consists of just a few attorneys. Junior attorneys, in most cases, handle complaints and preliminary matters, and the more senior personnel handle trials.

A number of smaller offices have informally established procedures whereby one assistant prosecutor handles all rape cases. In one, a case is assigned to a two-person trial term after an indictment is returned. Under a new informal policy, one assistant becomes involved at the beginning and attempts to follow the case to trial.

2. *Staffing impact on victims.* From the complainant's perspective, having to deal with more than one prosecutor has a number of deficiencies. First, it makes it difficult, and in some instances virtually impossible, for the complainant to locate the appropriate attorney to obtain information about her case. Even if the complainant knows whom to contact, it is

not always an easy matter to locate that attorney.

Such a lack of continuity also tends to put an upper limit on the rapport that can be developed with any one prosecutor. This could well result in certain information never coming to the attention of the attorney ultimately responsible for trial of the case.

Virtually all prosecutors interviewed believed that a system permitting a case to be assigned to a specific prosecutor at entry level would work both to ease the process for the victim and to increase the quality of the legal work done, and, hence, the ultimate conviction rate.

The primary prosecutor argument against such a system is the financial consequence of increased attorney "downtime" when not handling specific cases. Also there seemed to be concern that the increased time expended by each attorney on each case would cut the total number of cases one prosecutor could handle, thereby increasing the real cost to the office. Similarly, some prosecutors felt that one-to-one case assignment could result in highly experienced and highly paid prosecutors performing papering and preliminary functions that could be more economically performed by lower-ranking personnel.

It was pointed out by other prosecutors, however, that proper handling of the early stages of a matter, particularly a rape case, may be crucial to the success of the prosecution. In many instances cases are lost or dismissed precisely because errors were made, either in law or judgment, at the critical early stages. They also felt that the crime of rape, as other major felonies, such as frauds, homicides, or narcotics violations, warranted a special substantive unit with attorney continuity, expertise, and comprehensive joint development, especially in those larger offices that had the freedom to shift personnel around.

3. *Staffing modifications.* A number of prosecutors' offices have experimented with modifications in their traditional staffing design. Most of these changes are of recent origin.

a. *Special sexual assault unit.* Some prosecutors' offices have established separate substantive units to handle rape cases and, in some instances, other sexual assault cases as well. They are located in Seattle, San Francisco, Manhattan, Nassau County, New York, and Queens, New York. The theory behind these units is that they can better foster expertise in the prosecution of sex crimes, which will, in turn, result in higher conviction rates. A second premise is that selection of personnel for the unit can be based on sensitivity as well as competence, thereby easing the court process for the victim. Thirdly, the unit can provide attorney continuity.

The Seattle Morals Unit is, in essence, an office within an office. This unit handles all cases involving sex crimes, from indecent exposure to rape. One problem, however, is that the unit is effectively subdivided into complaint, preliminary hearing, and trial sections. Assignments are made on a rotating basis, lasting not more than a week in preliminary hearings, to several months in trial. During the course of the proceedings, therefore, the victim may deal with three or four different attorneys.

Once the complainant has finished her police interview, she is questioned by a prosecutor member of the unit. At this point, the prosecutor makes an initial decision to file or not file the complaint based on a preliminary determination of whether the case could be won in court.

A different prosecutor often deals with the victim at the preliminary hearing stage. This hearing can be an ordeal for the victim, because some attorneys use the hearing to see how she holds up with stiff questioning from defense counsel, in some cases with no advance preparation by the prosecuting attorney. Then at the trial a third prosecutor may be responsible for her case.

In other offices, a member of the sexual assault unit becomes involved in a rape case at the initial stages and remains with it through the trial. This attorney's responsibility also includes coordination of the field investigation with the police detective assigned to the case.

These separate sexual assault units came about through work by aggressive prosecutors, pressure from feminist groups, and public exposure. Probably as a result, three of the five units are headed by women prosecutors. However, there is no current data and little evidence either in support of or against the supposition that a woman prosecutor necessarily will be more sensitive in her treatment of the complainant; or that complainants generally prefer to deal with a woman; or that women prosecutors have greater success with juries. Prosecutors interviewed were about evenly split on these issues.

b. *Team prosecution.* A second staffing modification, found in Kansas City and Austin, involves the use of a team of two prosecutors for rape cases. Typically, one person (usually the junior attorney) becomes involved at ground level and follows the case through to disposition. This provides continuity and training for newer attorneys. It also reduces the chance of inefficiency resulting from preliminary matters and other routine work being handled by senior personnel. Defenders of the team prosecution concept, especially for rape cases, make the point that team prosecution can provide a good deal of support for rape victims who often need extra assistance during court proceedings.

C. Use of Non Lawyer Personnel

A number of prosecutors' offices are experimenting with the use of staff members who are not lawyers. These include law students, paraprofessionals, psychiatrists, and victim or witness support persons.[1]

1. *Students and paraprofessionals.* Several prosecutors' offices are using law students and paraprofessionals as clerks, investigators, and trial preparation assistants. In some instances, evening students are used on a full-time day basis in positions of substantial responsibility.

In Queens, a special rape subunit has been set up within the Major Offense Bureau, which includes two assistant district attorneys, two investigators who are not lawyers, and a trial preparation assistant, also not a lawyer. Cases processed by this subunit (approximately one-third of all sexual assault cases) are handled by one prosecuting attorney and an investigator, generally a law student, from the time charges are filed until trial. This provides more continuity for the complainant and gives her greater access to information about her case. In addition to normal research and investigative duties, such as locating and interviewing witnesses, the law students in this program developed liaison with other local institutions and organizations dealing with rape matters, such as hospitals, mental health facilities, and citizen groups.

2. *Psychiatrists.* The Manhattan District Attorney's Office has received funding for a rape unit that will include–in addition to prosecutors, nonprofessional investigators, and trial preparation assistants–the half-time services of a psychiatrist. The psychiatrist will provide crisis counseling for victims of sexual assault and assist staff attorneys in developing trial strategies

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[1] In other handbooks in this report, persons performing similar functions are called victim support persons. Here they are referred to as witness support persons because of the growing number of programs in prosecutors' offices that include support persons for witnesses to all types of crimes.

based on psychiatric insights, a novel experiment.

Attorneys, including both prosecutors and representatives of the New York defenders' association, believe that this program may raise a number of serious legal questions. Will, for example, the complainant be more vulnerable at trial to charges of emotional and mental instability because she has been under a psychiatrist's care? Will the full doctor-patient privilege be applicable? For instance, can the psychiatrist be forced to testify by the prosecutor, even if the complaining witness objects? Can a defendant subpoena the psychiatrist over objections of both the prosecutor and the complaining witness? One of the benefits of this experiment will be to help answer some of these questions.

3. *Victim and witness support staffs.* A number of jurisdictions are launching victim aide and witness support programs within the prosecutors' offices. The hope is to reduce greatly the number of trials adjourned or dismissed because of missing witnesses.

The three-person Milwaukee witness support staff provides continuous personal contact for witnesses (including victims), even though there may be two or more prosecutors handling the case. They also counsel witnesses and victims and are responsible for securing transportation and babysitting services when necessary. Further, the unit engages in community education efforts with citizen groups, the media, police, and local medical facilities.

A similar program in Portland, Oregon, has added a nonlawyer victim "advocate" (support person) to the staff of the prosecutor's office. The support person enters a rape case at the earliest possible point, preferably at the original police or hospital contact. Prior to the in-depth police interview, she counsels the victim about its necessity, including the recitation of the more embarrassing details and then sits in on the interview with her. She also accompanies her to the hospital and to all subsequent interviews and court proceedings. The support person acts as counselor, coordinator or support services, and follow-up referral source, and also works with community education and public information programs in Portland.

D. Modifications of Court Procedures

Another area in which a few concerned prosecutors have succeeded in easing the process somewhat for rape complainants is through formal and informal modifications of court procedures.

1. *The preliminary hearing.* The preliminary hearing can be a brutal experience for the rape victim. Often, it is conducted by a lay magistrate or lower court judge who lacks sensitivity to the issues and who exercises little control over the far-ranging sharp, and, often, deprecating cross-examination techniques of defense counsel. The victim feels on trial herself, as her credibility is attacked over and over again and her prior sexual history is exposed in intimate detail. In some communities, prosecutors do not even attend preliminary hearings or brief victims beforehand. The victim is alone, frightened, embarrassed, without counsel or support, and surrounded by hostile forces.

Even when an assistant prosecutor is present, he or she may have so many hearings that there is not time to interview the victim more than a few minutes in advance, if at all. Frequently, she is left largely to her own devices; she even may be accosted in the halls by the friends or family of the defendant, if not by the defendant himself.

Efforts are being made by some prosecutors to minimize these difficulties. In Kansas City, hearings in sexual assault cases are all scheduled for a specific afternoon, so that the complainants can provide mutual support to each other, and the courtroom atmosphere is not likely to be so hostile.

Until recently, in Philadelphia, preliminary hearings in all rape cases were conducted in the precinct by lay judges or magistrates. Consequently, little control was exercised over the manner and scope of cross-examination. Through the efforts of two concerned prosecutors, preliminary hearings in rape cases now have been moved to a much more controlled atmosphere, in a central location, and are conducted by law-trained judges.

2. *Grand jury.* In certain jurisdictions, it may be possible to bypass the preliminary hearing stage and go directly to the grand jury. Unlike the preliminary hearing, the grand jury does not permit defendant's counsel to appear, and it would be rare for the defendant and victim to be present at the same time. In addition, grand jury proceedings, because of the presence of the prosecutor (and absence of defense counsel), do not normally involve brutal cross-examination sessions with the victim, if she is present at all.

In many jurisdictions, however, a grand jury is not convened for rape cases at all. The U.S. Constitution does not provide a defendant the right to a grand jury for nonfederal cases, although some state constitutions do.

Given the one-sided nature of a grand jury presentation, it is only realistic to expect an indictment to be the usual result unless the prosecutor has erred significantly or extralegal factors are in operation. For instance, in such cases as politically sensitive crimes and rapes, trial jury acquittals are often reputed to be based on the extra-legal factor of a judgment of the complainant's character and/or behavior, rather than solely on the defendant's guilt or innocence under the law. A similar process can operate among grand juries, resulting in few indictments when the victims are hitchhikers or alleged prostitutes.

In at least one jurisdiction, the prosecutor attempts to use the grand jury in this manner, primarily to avoid the ordeal of trial for complainants whose cases do not appear strong. More commonly, cases involving hitchhikers or prostitutes are either not presented to the grand jury, are plea bargained to significantly lesser offenses, or are dismissed at various stages in the proceedings. Of the offices surveyed, only Portland, Oregon, claimed it to be office policy to regularly take such cases to trial.

In a few jurisdictions it is possible to bypass both a preliminary hearing and a grand jury by proceeding directly on information filed by the prosecutor. In Florida, it is also possible, when a capital offense is not involved, to proceed by information and eliminate the preliminary hearing and grand jury. However, the U.S. Supreme Court is presently reviewing the constitutionality of a procedure under which the only determination of probable cause before the trial is that made by the prosecutor.

3. *Law reform.* Statutory and legal reforms concerning rape are being undertaken by a number of law reform commissions, state legislatures, and women's organizations. (See the Citizen Action Section.) However, few prosecutors' offices play a significant role in law reform movements, although a number of individual prosecutors have been active in statutory drafting and giving advice to reform commissions.

Apart from such practical limitations as time, personnel, and funding, this nonparticipation in law reform derives from certain characteristics of the legal system. For example, concern that the constitutional rights of the defendant be adequately safeguarded has produced a system whereby there are few issues that can be appealed by the prosecution. Most prosecutors maintain that judges tend, therefore, to err, if at all, in the defendant's favor and are reluctant to even consider judicial law change favoring the prosecution. Consequently, few prosecutors press such changes. It should be noted, however, that some legal issues involved in rape cases, such as corroboration requirements, have been sufficiently debated and publicized that some judges have gone out on judicial limbs in declaring corroboration unnecessary in spite of clear appellate case law to the contrary. Certainly this would not have occurred if the prosecutor's office had not researched the issue and presented strong arguments for consideration.

Some of the key issues undergoing review by courts and legislatures are the following:

- Eliminating victim corroboration requirements that still exist in a few states for rape only;
- Limiting the need for the victim to testify to her prior sexual history, especially where the defense is other than consent;
- Clarifying the degree of force or resistance required to overcome the consent defense;
- Shifting the prosecution's burden of proving lack of consent beyond a reasonable doubt, to the defendant, as is done in other affirmative defenses;
- Circumscribing the use of such cautionary instructions to the jury as "rape is a crime easily alleged and difficult to defend against"; and
- Changing mandatory death sentences for any kind of rape to more flexible sentencing options, perhaps by breaking the crime into degrees and lesser included offenses.

E. The Victim's Role in the Prosecution

Perhaps one of the greatest sources of misunderstandings and displeasure of rape complainants relates to their seemingly insignificant place in the prosecution and in the criminal justice system.

1. *Victim as evidence.* In a purely conceptual sense, the complainant in a prosecution for rape is evidence that the crime has occurred and that it was the defendant who committed it. A criminal prosecution is the state's remedy for a crime committed against the laws of the state.

A woman who has been raped, however, will quite understandably feel that it is she, rather than the state, who has been offended. She will tend to view the criminal justice system as one way she can redress this very personal wrong. A contributing cause of this misconception is the paucity of civil remedies for rape. Although a civil suit would be appropriate, most rapists, particularly if incarcerated, are judgment-proof. Remedies based on theories of third-party negligence in providing inadequate security in apartment units, university complexes, hospitals, and other areas where women are frequently attacked, have proved fruitful in very few cases.

Hence, the victim has only the criminal justice system through which to vindicate the wrongs perpetrated upon her. And this road can be tortuous, vexing, embarrassing, and uncertain. Once the court process is begun, the complainant will find the situation out of her control in most respects. While a few prosecutors may seek to keep her informed of the progress of the case, she is unlikely to be consulted on such matters as defendant's bail, acceptance of his pleas to a lessor offense, or possible sentencing options.

Even for genuinely concerned prosecutors, the dichotomy of state and victim redress is a difficult one to solve. In rape cases, perhaps more than in other crimes, it is apparent that society's interest in convicting rapists may not be the same as the victim's. For example, prosecutors often do not raise objections in the courtroom to vicious defense questioning of the victim's prior sexual experience. They fear that doing so may cause the jury to believe the victim has something to hide. Her personal right to privacy must be sacrificed to the prosecutor's real objective of convincing the jury and convicting the defendant. Still, no prosecutor interviewed believed that the victim ought to have a separate victim attorney advocate "represent" her own personal interests, although such an advocate has recently been mandated by statute in California.

2. *Recognition of victim's interest.* There is a growing trend among prosecutors to try to involve the victim in certain aspects of the conduct of the prosecution. In a few areas, prosecutors now consult with the victim on her receptivity to defendants' pleas to lesser offenses. At least one judge in Minneapolis uniformly questions the complainant before a plea is accepted.

Of perhaps even greater significance to the complainant is the issue of whether or not she should be allowed to withdraw from the prosecution once charges have been filed. Office policies varied widely on this issue, ranging from one that would subpoena the complainant if necessary to keep the case going, to those that allow her to withdraw almost at will.

By far the bulk of the prosecutors' offices interviewed fell somewhere between these two extremes. A number avowed that the complainant could not withdraw except under exceptional circumstances, and more claimed that such problems were handled on a case-by-case basis.

F. Prosecutorial Functions

There are a number of prosecutorial functions that overlap with those of other agencies in the criminal justice system.

1. *Filing charges.* When a victim reports on alleged rape to the police, it is generally a police responsibility to develop sufficient evidence showing that a crime has been committed and that a given individual was responsible for it. The police also are charged with locating and apprehending the suspect. Once this has been accomplished, or in some cases upon identification of the suspect without apprehension, the case is given to the prosecutor for the filing of formal charges. When the suspect has been apprehended and the evidence collected and processed, the duties of the police traditionally are limited to testifying at court proceedings.

In some communities, police regularly seek prosecutorial guidance in making the decision whether or not to proceed with a complaint. In others, prosecutorial input at the entry level is even greater. For example, in San Francisco, prosecutors review all felony complaints and help direct the police investigation from its inception.

In most jurisdictions the prosecutor does not enter the case before the complaint is filed. However, in some locations, one person from the prosecutors' office (sometimes a victim aide) tries to sit in on the victim's initial police interview with the detective. These offices claim this helps them develop the needed rapport with the victim, ensures a hand in their initial investigation, and maintains continuity between police, prosecution, and victim.

2. *Investigation.* Generally, prosecutors' offices do not participate with police in the investigation phase of a rape case. However, where prosecutors have established separate sex crimes units there is greater prosecutorial coordination with the police investigation, supervision, and collection of evidence than usually exists.

In other communities, some prosecutors have undertaken limited investigative duties as part of their effort to develop substantial rapport with the victim and to improve trial preparation and conviction rates. Much, of course, depends on the prosecutor's relationship with the police and the workloads of each agency. Most prosecutors agreed that it was better to seek improvement in police investigatory practices than to undertake this responsibility themselves.

3. *Contact with victim.* Most often, the victim's first contact with the prosecutor's office comes when a complaint is prepared and filed. This usually is done in a large, noisy, crowded office. Often the victim is left unattended to sit for a number of hours while the necessary papers are drawn up. Then she meets the charging attorney who may be the least experienced attorney in the office, is overworked, and may not be familiar with the kinds of evidence needed to prove the case at trial. Thus, the victim's initial contact with the prosecutor's office may discourage her from enthusiastic cooperation.

The preparation of the victim and other witnesses for the trial proceedings is an important prosecutorial function. This includes both interviews before the actual trial and those prior to all preliminary proceedings during which the witness is to testify. Preparation not only informs a witness how to respond properly to questions put by counsel, but also helps prepare her for this experience, so as to minimize its traumatic effect. A witness, especially the victim, is often frightened, confused, and reticent. She probably has never appeared at court before. She needs all the comfort, assistance, and concern a prosecutor can muster. Although some prosecutors feel she should not be "overprepared," lest her story seem artificial and contrived, most agree that the whole court process should be explained to her, and that she should be made to feel she is an important part of the system.

G. Training for Rape Cases

Few jurisdictions provide special training for prosecutors who will be handling rape cases. The only instances encountered were in Minneapolis, where the district attorney conducted training seminars on special victim sensitivities for assistant prosecutors, and in Kansas City, where the training was accomplished somewhat more informally. There was almost complete unanimity that the only real training for prosecuting sex crimes was experience, either as an apprentice or as a member of a prosecution team.

H. Coordination with Other Agencies and Groups

1. *Police*. As noted earlier, successful prosecution of any case depends on effective coordination between police and prosecutor. This can occur in at least three important areas: investigation and collection of evidence, founding a complaint, and police testimony in court proceedings. Very few officers surveyed had developed cooperative relationships with the police in all three areas. One of the greatest gaps occurred in securing the chain of custody of evidence taken by police or hospitals.

Another subject being explored in a few jurisdictions is participation by the prosecutor's office in police training sessions.

2. *Medical facilities*. At least as crucial in rape cases as proper linkage between police and prosecutor is coordination between medical personnel and prosecutor.

Even where there is not a formal corroboration requirement, strong medical evidence is invaluable in convincing juries that the complainant was in fact raped and in establishing the identity of the rapist. Corroboration of penetration usually takes the form of physical evidence as to the presence of semen, which can be determined by various laboratory tests. Equally important in many cases is medical corroboration of force. This is the area where physical evidence can be crucial and testimony is generally required from the attending physician. Yet doctors are not usually accustomed to looking for or recording nonmedical corroborative evidence (such as grass stains, pubic hairs, or threads from clothing). They are also notoriously reluctant to testify in court, and consequently are much less thorough in their reports than they could be. Not infrequently, one hears reports of actual falsification on medical records in order to avoid court involvement.

A few prosecutors' offices have undertaken to work on this problem. In most cases, this appears to be the result of participation in many broader-based community groups, such as a mayoral task force. Such groups are useful in bringing the problem into focus and underscoring the fact that no one is taking responsibility for solving it. As a result, some offices are participating in drafting medical protocols and helping physicians learn how to use them to best advantage. Thus they can help physicians avoid some of the pitfalls that open them up unnecessarily to skillful and uncomfortable cross examination. In Queens the district attorney's office is establishing rape liaisons with all the hospitals within its jurisdiction.

Part of the reluctance of doctors to testify is due to the possibility that they will be required to spend many hours waiting for their turn as witnesses and may also encounter other scheduling problems or delays that cause them to lose time from their work. In one jurisdiction, closed circuit television is being used on an experimental basis as a substitute for in-person court appearances by doctors. The doctors, via television, can testify from a location within the hospital and be questioned by attorneys in the court room.

Another means of securing doctors' cooperation is the use of certified written reports for preliminary hearings, thus eliminating the need for doctors to make a personal appearance at that point in the court process. Prosecutors who favor this technique suggest that the use of certified reports should be statutorily guaranteed to insure their acceptability as evidence.

3. *Citizen community groups*. Another substantial problem is liaison with community groups. Relations with feminist groups, particularly rape crisis centers, are frequently tense, when they exist at all. The major issue in most cases is reporting. Since rape convictions are so hard to obtain, even with the best efforts of police, hospital, and prosecutor, a number of rape crisis groups have taken the position that reporting is futile. They either discourage women from calling the police or, at the least, do not affirmatively encourage them to do so.

Quite naturally many prosecutors view this as obstructionist. In a few areas, notably those with active task forces, prosecutor's offices and crisis centers are beginning to recognize a community of interest and are attempting to work out their difficulties.

Rape crisis centers or representatives from other women's groups have also come into conflict with prosecutors' offices over the question of the level of involvement of rape advocates or other supportive personnel in the prosecutorial process. Demands that these persons be allowed to sit in on interviews have evoked significant hostility. Prosecutors tend to view such advocates as meddling or irrelevant and resist the suggestion that anyone other than the police detective can play a legitimate role in the case. They also appear not to take the concerns seriously, thus further alienating the representatives of the women's groups with what comes across at best as professional snobbery and at worst as blatant sexism.

There are a few examples, however, of constructive collaboration between women's groups and prosecutor's offices. For example, evidence that a rape victim had called a rape hotline immediately following the attack was successfully used to offset the effects of late reporting at a jury trial in Los Angeles. Advocates in Philadelphia may accompany the victim to various court proceedings and insulate her from possible contact with the defendant, his family or friends. In Kansas City, women's groups have organized "court watchers" to sit in on rape trials and support the victim in testifying.

4. *Other*. Some district attorneys have worked out informal agreements with the press so that the victim's name is withheld from the papers. A number of prosecutors participate in community education programs, either alone or jointly with police, hospital, and community group representatives. Others participate in task forces with representation from police, hospitals, and other community interests. In most cases, successful relations with community groups seem to hinge primarily on the personalities involved and their decision that it is worth the effort to collaborate. This, in turn, seems to depend on the degree to which each has recognized the mutual advantage of joint efforts.

CHAPTER IX. GUIDELINES FOR THE MANAGEMENT OF RAPE CASES BY PROSECUTORS' OFFICES

A. Overview

The guidelines that follow are offered as suggestions that may be helpful, depending on the conditions existing in specific communities. For the district attorney with a small budget and little staff, some will not be relevant. For the larger urban offices, more may be useful, again, considering local relations with police, medical facilities, citizens' groups, and judges, plus local statutory law and procedure. Some of these guidelines may be implemented only in the best of worlds—these should be thought of, perhaps, as goals worth striving for. Others can be put into practice by most individual prosecutors. Still others may be appropriate for interdisciplinary municipal or state task forces seeking to enhance the response of prosecutors' offices to the crime of rape.

Six general principles should be kept in mind.

- Members of a prosecutor's office, with whom a rape victim comes into contact, should possess and display sensitivity, concern, and competence. These qualities are more important than the sex of the individual prosecutor.
- If possible, the prosecutor should enter the case at an early point to develop the needed rapport with the victim and to coordinate with the police investigation.
- Preferably, the number of different prosecutors dealing with a victim and to whom she must relate her story should be kept to a minimum. Ideally, one prosecutor, assigned to the case at entry, should retain responsibility for the case until final disposition.
- It is desirable to have witness (including victim) support persons available during the court process and to integrate this service into regular office procedures.
- There should be one person in the prosecutor's office (perhaps the witness support person) from whom the victim can readily obtain information at all times on the status of the legal proceedings.
- Investigatory and trial procedures should be streamlined to the extent possible, and consideration should be given to means of minimizing inconvenience to the victim and other witnesses so that their full cooperation is obtained and retained.

B. Organization of Prosecutors' Offices

1. *Separate units*. Larger offices, which have the flexibility, should consider the establishment of sex crimes or sexual assault units for the prosecution of all rapes. The establishment of such a unit provides a number of benefits to both prosecutor and victim. Primarily, it facilitates the growth of expertise in all aspects of the prosecution of sex offenses, from understanding the special problems of rape victims to developing superior courtroom skills and tactics. Such a unit also creates an institutional device for lawyer recruitment and training. New personnel can be selected with a view toward providing flexibility and sensitivity, as well as competence. A special unit also provides needed attorney

continuity to victims who may be confused or frightened.

In jurisdictions where the case load does not justify a special unit or a full-time prosecutor, one individual should be assigned to handle sexual assault cases. This person could perform other duties as needed to maximize efficiency. Such offices would probably be small enough that substantial flexibility could easily be built into office procedures.

In jurisdictions where the office of the prosecutor is organized primarily on the basis of courtroom assignment, two possibilities should be considered. Witness support units, if they already exist, could be fully integrated into the prosecutor's office procedures. Funding should be sought so that the support group can insure the continuity which the attorneys cannot. If a support group does not exist, consideration should be given to creating one that is directly affiliated with the prosecutor's office. It should be noted that such witness support units are most effective when coupled with a prosecutorial sexual assault unit.

In some instances, the supposed difficulties of creating a distinct unit for the prosecution of sexual assault cases are more apparent than real. If the physical location of the various courts and office branches does not present insurmountable obstacles, appropriate cases could be tagged at entry and assigned to a special unit with little or no disruption to the workings of the system.

Under such a modified system, when a rape or other sexual assualt case is called, the prosecutor normally assigned to that courtroom would be released to work on other matters.

Some initial outlays for a systems analyst might be required to accomodate the changes within any computers being used, and there would be some shuffling of office space and staff, but the problems would primarily be logistic. Once such a system were implemented, it would probably not require significant additional resources to maintain.

2. *Assignment of rape cases to individual prosecutors*. Assignment of one prosecutor to handle a rape case from entry to disposition appears to have significant benefits for the victim and for the ultimate success of the prosecution. This is as true for prosecutors within special sex units as it is for those in other types of office organization.

It is essential that the prosecution not have an unwilling or uncooperative complaining witness. The victim's confidence and cooperation should be obtained early in the prosecution and maintained throughout. Minimizing the number of prosecutors with whom she may come into contact and, particularly, to whom she must relate the sordid details of the events, furthers this goal.

Also, the more familiar a prosecutor is with a case, the better are the chances of obtaining a plea or ultimate guilty verdict. Limiting the number of individuals working on a case, moreover, reduces the chances of error through oversight, misunderstanding, or neglect.

One-to-one case assignment facilitates entry of the prosecutor at the earliest practicable point, enhancing the likelihood of rapport with the victim and sound case preparation. Because of the central importance of the victim to the case, her need for understanding, concern, and reassurance of a one-to-one case assignment is especially preferred for rape cases as contrasted with some other (especially victimless) crimes.

One-to-one assignments, however, can be an inefficient system. In order to help guard against possible loss of "downtime" that may result from one-to-one assignments, several prosecutors' offices have offered these suggestions:

- Greater utilization of law clerks, paralegals, and investigators to more evenly distribute prosecutor work load. A number of traditional office functions may be delegated to law clerks or paralegals to conserve the prosecutor's time. Research, investigation, and many administrative duties fall in this category. Use of such personnel, under the supervision of the one prosecutor with ultimate responsibility for the case, enables this prosecutor to increase his or her own case load, and can result in both overall savings to the office and better preparation of cases.

- Prosecutor flexibility to perform other duties (such as misdemeanor trials, community education, or administrative matters) during periods of substantial lulls.
- Availability of other experienced prosecutors (not officially part of the rape unit) to take over individual cases on an "as needed" basis during periods of significant overload.

One-to-one assignment may result in more highly trained (and paid) prosecutors performing preliminary case functions that are usually undertaken by lower ranking personnel. However, as a number of prosecutors pointed out, proper handling of a case in the early stages of the prosecution is crucial to its eventual success. Mistakes made at the inception by inexperienced counsel are frequently damaging. They may be overcome only at the cost of significant later additional time and effort.

Again, a number of traditional office functions may be delegated to law clerks or paralegals to conserve the prosecutor's time. Research, investigation, and many administrative duties fall in this category. Use of such personnel, under the supervision of the one prosecutor with ultimate responsibility for the case, enables this prosecutor to increase his or her own case load, and can result in both overall savings to the office and better preparation of cases.

3. *Team prosecution.* Where resources permit, team prosecution within a sexual assault unit offers the best of all possible worlds. With such a system, two prosecutors, one junior and one senior, are assigned to each case. Under the close supervision of the senior attorney, the junior person performs most preliminary functions, including investigative work, if appropriate, and conducts the pretrial proceedings. This junior attorney acts as "second chair" at trial, and tries some of the more straightforward cases. This system also facilitates effective recruitment and training for the sexual assault unit.

Where prosecutors' officers do not have the flexibility to create substantive sexual assault units, and where one-to-one (or two-to-one) case assignment is impractical, we recommend the assignment, at entry, of a junior attorney, who would stay with the case to disposition, providing continuity for the victim and training for the prosecutor.

C. Use of Nonlawyer Personnel

1. *Information coordinator.* A common complaint of victims and witnesses generally is their inability to learn timely details about the status of their cases, hearing dates, and court procedures.

One person within the prosecutor's office (a secretary, law clerk, witness aide, paralegal) could be designated as the office information coordinator, with responsibility for maintaining accurate records of the status of all rape cases, and for contacting witnesses on a regular basis to inform them of the progress of their case. The coordinator can also answer most questions of a purely informational character, such as court dates, and can relay questions of a more personal or evaluative nature to the prosecutor involved. Such a system eliminates much of the frustration experienced by complainants trying to track down the right person to answer their questions and helps reassure them that the case is being prosecuted with due diligence.

Another possibility is to establish a joint police/prosecutor rape coordinator. One individual, operating out of either the police department or the prosecutor's office, undertakes responsibility for keeping abreast of developments in both departments. This person serves as a resource for victims and helps coordinate efforts between the two branches. This is particularly helpful in offices where the prosecutor has some investigative duties. Ideally, such an individual serves as a witness support person and performs other services as well. The position of coordinator, by its very nature, requires a full-time person, perhaps a night session law student.

If the case load permitted, the student could perform other functions as well, such as research and brief writing, thus making the position more attractive to law students and, probably, more economically feasible as well. Alternatively, a secretary or a witness support person could be designated coordinator. The coordinator must be sensitive to the victim's trauma and willing to devote adequate time to her. Otherwise, the victim will not be satisfied talking to anyone other than "her lawyer."

Clearly, having a coordinator involves some added expense. The real cost, however, is impossible to calculate. Certainly such a system frees prosecutorial time spent answering questions of a purely mechanical or administrative nature. It also can reduce significantly the number of cases dismissed due to missing or uncooperative witnesses.

A number of indirect benefits flow to the prosecutor's office. The advantages of a coordinator system are highly visible to the victim and may prove invaluable in combatting the widespread impression, particularly among minorities, that the system is uncaring and reporting is futile.

2. *Witness support persons*. In most medium and large prosecutors' offices, it would be desirable to have one or more witness support persons. The term, witness support person, as used here, includes victim support persons, victim aides, witness aides, and other types of support assistants. The duties of a victim support person could include information coordination. But the witness support person also can serve as a referral source by helping the victim secure follow-up medical treatment, counseling or mental health services, babysitting, and transportation assistance; accompanying the victim and other witnesses to preliminary hearings and trials; and making sure that the victim's privacy is not infringed by courtroom encounters with the defendant, his friends, or his family.

In some cases the victim is in real or perceived danger during the court process. The defendant is typically released on bail and frequently knows where the victim lives. If a threat of further violence has been made to the victim she may be afraid to proceed with the trial. For this reason, it is important that witness support activities include providing the options of temporary lodging, a cover identity, transportation to and from work, and intervention with job supervisors to secure the victim's safety.

In spite of the lack of data on the preference of rape victims for contact during the court process with sensitive men, as well as women, it is recommended that the majority of the witness support persons be trained women. A common complaint of rape victims is the difficulty of relating the details of a crime, perpetrated by one male, to another male. Although the number of women in medicine, police work, and the legal profession is rising, it is still true that most of the doctors, police officers, detectives, judges, jurors, and attorneys with whom the victim comes into contact are men. The presence of at least some sympathetic and understanding women as witness support persons is important. However, prosecutors must be aware of the risk of subpoena of these persons when assigning functions such as counseling to them. A counselor who is subpoenaed may become unavailable to provide needed emotional support for the victim at trial.

A later section of this chapter describes how witness support persons should coordinate their responsibilities with citizen groups, medical personnel, the police, and other community organizations.

3. *Research assistants*. In many prosecutors' offices, time pressures limit the amount of research that can be done, although such research is needed for the most effective preparation of individual cases for trial and for effecting law reform through judicial decision. Law students can help free up the prosecutor's time by

undertaking basic research, as well as by drafting routine motions and appeals.

Where they are available, law students are an inexpensive and useful resource. In some law schools, academic credit is given under internship programs, and students do not require remuneration. In others, such students are available at low cost under federal programs. A student intern program provides valuable training and experience for students, stretches limited prosecutorial budget resources, and can serve as a good recruitment vehicle for new prosecutors.

4. *Investigators*. In those jurisdictions where cases are handled by teams consisting of a prosecutor and student or paralegal investigator, trial preparation has been facilitated. The investigator adds continuity where more than one prosecutor is involved and improves the office's coordination with the police department.

5. *Translators*. Consideration should be given to the needs of rape victims who do not speak English. The prosecutor's office can greatly ease the isolation felt by many minority women by providing an information coordinator or a witness support person who is bilingual in localities where there are concentrations of people who do not speak English. Moreover, translators should be available for courtroom appearances and all interviews between the victim and the prosecutor.

6. *Difficulties in effecting change*. Even in offices aware of and interested in alleviating the difficulties inherent in the prosecutorial system for all witnesses, and for rape complainants in particular, it is frequently difficult to implement more than seemingly token changes in formal office procedures. It seems all but impossible to bring about radical change without tremendous support and cooperation from the community at large.

Major obstacles to change are the difficulty of conducting "scientific" experiments where important human values are at stake and the consequent paucity of research and experimentation.

Conditions in a prosecutor's office are not the most conducive to experimentation. However, one can (and should) experiment with novel arguments on such issues as the legal relevance of the complainant's prior sexual history, particularly in a case where the defense is other than consent. But it is more difficult to experiment with reforms, such as using video tapes of the complainant's testimony before the grand jury, or video-taped depositions for probable cause hearings or even for the trial. Since the courts do not issue advisory opinions and the only mode of testing innovation is "at the risk of the individual prosecution," a reluctance to experiment is wholly understandable.

The inertia of the legal system as a whole also weighs against change. Prosecutors' offices suffer from the same problems that affect the overall criminal justice system. There is the tremendous volume (and resulting backlog) of criminal cases, which has mandated such constitutionally questionable procedures as massive plea bargaining. Also involved are more practical limitations, including office size and funding limitations; political realities for elected officials, which include most district attorneys; organization of the court system and, in particular, the criminal justice system; and recruitment and training needs.

The size of the prosecutor's office, the court organization, and the geographic area included in the office's jurisdiction, also limit the extent to which significant internal change can be implemented without substantial outside funding. Similarly, the addition of a victim advocate or witness support person entails additional funding. The expenditures might be justified pragmatically through increased convictions, increased reporting, and, perhaps, a decrease in the commission of rape, but such long-range goals are not always highly visible.

Rural offices covering a large geographic area usually find it impractical to assign cases by subject matter rather than geographic location, since the attorneys' travel time would be too great.

Political considerations come into play in determining whether staffing or procedures should be modified to deal with rape complainants and also affect decisions on what modifications should be made. The most common example may be the determination that a rape unit should be headed by a woman. It is generally accepted that the person chosen to head a rape unit should be experienced as a prosecutor and should have the warmth and sensitivity necessary to communicate with the victims of this traumatic crime. Expedient political decisions that place an inexperienced person in this role have been shown to do a disservice to the victim, to the person chosen as prosecutor, and to the prosecutor's office. A hiring decision based on qualifications for the job of special rape prosecutor has proven more successful.

Internal change appears also to be hampered by the fact that organizational options for prosecutors' offices are substantially limited by their necessary relationship to the structure of the local criminal justice system.

Consideration has been given to establishing a sex crimes unit in Los Angeles, with about 10 to 12 deputies. It is clear from the mechanics of the court system there, however, that such a project would, in effect, necessitate the creation of a separate district attorney's office for the prosecution of sex crimes. Although such units have been established for prosecuting major frauds and pornography cases, the transportation problems caused by geographical centralization might be even more burdensome to the victim than having to deal with two to four attorneys during the course of the proceedings.

Even where establishment of a special sex crimes unit appears administratively feasible, there are other considerations. For example, one important advantage of a special unit to handle sex crimes is the opportunity to develop expertise among those in the unit. However, unless the unit operates at least to some extent on a team prosecution basis, the only way for incoming prosecutors to build the required expertise and experience is to start by handling the less crucial aspects of the prosecution, such as preliminary hearings, motions, complaints, etc. This would cause exactly the situation the special unit was intended to cure: the complainant having to deal with a series of different attorneys.

D. Modifications of Court Processes

There is little that individual prosecutors can do to alter court processes in many jurisdictions. They may involve vexing delays for the victim, subject her to harassment and intimidation by defense counsel, and are often long and drawn-out. When the victim can be spared an unnecessary inconvenience, when she can be prepared and briefed ahead of her appearance, this should be done. She also needs the prosecutor's understanding, support, and demonstrated concern.

There are, however, some changes that can be made in the system to make it more humane. For example, it may be possible in some jurisdictions to bypass the preliminary hearing and proceed directly before the grand jury. Also, consideration should be given to taking the hearsay testimony of the police officer at the preliminary hearing without requiring the direct testimony of the victim. Or, in areas where lay magistrates have proven problematical in rape cases, it might be practicable to move preliminary hearings out of lay magistrate precinct courts into the more controlled atmosphere of the next level court, with law-trained judges.

Efforts, also, should be made by prosecutors to facilitate court appearances. Some suggestions are:

- Clearing the courtroom for the victim's testimony, particularly at hearings on preliminary matters. This may well require the cooperation of the participating judge or the defense counsel.
- Arranging for a witness support person to accompany the victim to all proceedings. Such an individual could either be directly attached to

the prosecutor's office, or be from another community agency or group.

- Minimizing continuances, and when continuances are sought, providing advance notice to witnesses.
- Arranging to have certain witnesses on call, rather than having them wait in the courtroom until the case is called.
- Having a private area or waiting room for the victim to insulate her from unnecessary contact with the defendant and his family and friends.
- Ensuring that the victim knows in advance and has been adequately prepared for each appearance.
- Developing a comprehensive brief that the victim's prior sexual history is legally irrelevant and making every effort to eliminate unnecessary questioning and testimony along these lines.
- Providing special training for prosecutors handling rape cases.
- Scheduling all pretrial hearings on sex matters at a specified time, so that rape victims can provide mutual support for one another in the courtroom.

The physical location of prosecutor interviews might also be improved. Where there has been an immediate arrest, the victim is frequently shuttled between the hospital, police precinct, and prosecutor's office in rapid succession. In many urban areas, the place in which complaints are processed and filed tends to be noisy and intimidating. Often the victim is left sitting unaccompanied for long periods of time in a large hall with scores of other people. In such cases, a private waiting area should be sought, if only the office of the prosecutor. Arrangements should be made for someone such as a witness support person to wait with the victim, to bring her coffee or sandwiches, and to learn the reason for any long waiting periods. Some prosecutors suggest conducting interviews in locations other than their own offices, such as a park, the hospital, or the victim's home.

Sometimes even a little matter like reading out the address or apartment number of the victim in open court can be a source of agitation, especially if the victim believes that the defendant's friends may use that information to further harass or intimidate her. The small kindness of informing a victim when her alleged rapist has been released on bail may be of great importance to her.

Many of these suggestions envision a victim frightened, tense, emotionally upset, and confused. Of course, not all victims need the same degree of extra assistance. However, the prosecutor should make an early assessment of the victim's emotional condition and state of mind and realize that she may well need a generous portion of concern and understanding, over and above that normally associated with other criminal matters.

E. The Victim's Role in the Prosecution

While the criminal justice system perceives the crime of rape as an act against society and attempts to redress its social wrong, it was, in fact, the victim who was assaulted. Because the victim has a very personal interest in the successful prosecution of the crime, she should be given a voice in certain aspects of the conduct of the prosecution. This would include the freedom to withdraw from the case if she feels she cannot withstand the pressures and would also include participation in decisions concerning acceptance of possible pleas to lesser offenses and sentencing options.

1. *The decision to file charges*. Prosecutors are invested with significant discretion in determining whether or not to file charges and what charges to file against a defendant. Frequently, this decision is based on little more than a pragmatic determination, grounded in experience, that a given case is factually too weak to be worth the effort of trying to obtain a conviction. From the victim's perspective, however, this is commonly perceived as disbelief of her story or a lack of concern about the criminal assault.

The decision of whether or not to file charges should be made only after lengthy consultation with the victim, and her wishes in this regard should be given real consideration. Prior to any filing, the prosecutor, police detective, victim, and witness support person, if any, ought to confer, and the victim should be advised of the nature of the court proceedings to follow, the legal and evidentiary problems raised by her case, the probable areas in which she will be cross-examined at trial, and the likelihood of a plea or guilty verdict. She should also understand her civic duties of cooperating with the law enforcement process.

On the basis of this information, the victim is better able to make the decision whether or not she wants to go forward. If not, and if no plea can be obtained from the defendant, it may be that the case will have to be dropped. If the victim agrees to go forward with the prosecution, it should be understood that, barring serious unforseen difficulties, she is expected to persevere to disposition.

On the other hand, should the prosecution believe, for example, that the case cannot be won because of extralegal reasons, such as the lifestyle of the complainant, the prosecution may choose to close the matter. In such case, at least the victim would not feel that she was being called a liar. Thus, this initial conference can help both the victim and the prosecution make a better assessment of the fundamental considerations involved in a decision on whether or not to file charges.

2. *The decision to withdraw*. The right of a victim to withdraw from the prosecution after commencement admits of no easy solution. Once the victim has committed herself to the prosecution, it is fair to advise her that withdrawal is expected only for good cause, such as her health and well-being.

3. *Participation in other decisions*. If possible, other major decisions affecting the prosecution should also be deferred until after talking with the victim. For example, she should be consulted before a plea is taken to a lesser charge, and her wishes in this regard should be given full consideration. Sometimes, acceptance of a plea to a lesser charge might carry the implication of the victim's consent to the sexual act, and the victim should be aware of the elements of the crime to which the plea is being accepted. Similarly, if a victim is reluctant to go to trial and strongly prefers that the case be disposed of by plea to a lesser offense, her preferences should be considered. In addition, it is desirable that the victim be consulted and informed of sentencing options that the prosecutor will urge upon the court, either after a plea has been accepted or after trial.

4. *Advising the victim of possible legal rights*. The prosecutor should advise the victim of the existence of other legal rights she may have, such as a civil cause of action or compensation under a victim compensation statute. Whenever possible, she should be encouraged to seek legal counsel to assess her civil remedies. Referral to the local bar association, lawyer referral service, or neighborhood legal services office may be appropriate. Ordinarily, she will not need private counsel to recover under a victim compensation statute, if one exists in her state. (See Appendix IIA, for a compilation and discussion of such statutes.)

F. Training

Special training in rape matters is suggested for prosecutors. Attention should be focused on such issues as developing sensitivity to the special needs of the victim, and on particular legal problems involved in rape cases, with an eye toward more effective prosecution and the possibility of securing law reform through the avenue of judicial decision.

In offices using the sex unit or team prosecution approach, much of this training can be provided on the job. In addition, seminars might be conducted by experienced prosecutors, with the assistance of representatives from the police, medical facilities, and citizen groups. Such community involvement serves the dual function of alerting incoming attorneys to the particular difficulties faced by rape victims and of encouraging the cooperation of other groups in reporting rapes and assisting victims during the legal process.

G. Coordination with Other Agencies

1. *Police*. Prosecutors' offices should strive for closer cooperation with police departments in at least three important areas: founding complaints, investigation and collection of evidence, and joint training.

While practice on founding complaints varies from jurisdiction to jurisdiction, at least the prosecutor's office and the police ought to articulate their concerns to one another and establish working principles. Most prosecutors suggest that the police should found all complaints except obvious falsifications. Thereafter, prosecutor, police, and victim (and, possibly, a witness support person) should sit down together in making the decision of whether or not to file formal charges.

In most communities, investigation remains the exclusive province of the police. Prosecutors should work closely with police to encourage them to fully develop their investigatory capabilities. It is important for prosecutors to have at least some initial contact with police investigation units, if only to make sure that the evidence sought and collected will be admissable and valuable in court. In those jurisdictions where prosecutors share some investigating responsibilities with police, it is good practice to have lines of authority between the two agencies clearly delineated. Prosecutors should know the capabilities of police crime labs and ought to work out with them a clear chain of custody of the evidence, which will not be subject to successful defense challenges. This includes knowledge, at all times, of who has access to such evidence and its whereabouts.

Cooperative training arrangements with the police are desirable both in founding of complaints and in the investigation, collection, and chain of custody of evidence. Training in recognizing the particular needs and sensitivities of rape victims is also a good practice. As statutes, court rules, and judicial decisions change existing legal procedures, these changes need to be communicated immediately to police officials. Prosecutors, further, can be helpful to police in preparing them for testimony at court proceedings and in arranging "on call" status when appropriate.

2. *Medical facilities*. Prosecutors' offices should work closely with medical facilities to develop acceptable court-tested medical protocols for the examination of the victim and collection of extrinsic evidence. Evidentiary tests should be mutually agreed upon, and care should be taken that any hospital lab work is closely coordinated with police laboratories. Also, as is the case with the police, prosecutors should ensure that evidence collected by medical facilities is secured in such a manner as to withstand challenges to its chain of custody.

Another area where prosecutorial assistance is generally welcomed by the medical profession is in the provision of forensic training for physicians and medical personnel who treat rape victims. One concern here is to establish a reliable system for processing medical records so that they will be admissible in court with a minimum of oral testimony, will not be open to challenge by defense counsel, and will not reveal evidence that may be damaging to the victim and irrelevant to the facts of the case. (See the discussion in Chapter III of the Medical Facilities section.) Medical evidence can be stipulated too as a matter of course in many courts, and this spares doctors the necessity of testifying. Careful attention to the medical records and the method of processing medical evidence can help smooth the acceptance of the evidence at the trial.

Once legally adequate forms have been developed with medical facilities, doctors, nurses, and others involved should be carefully instructed in their use. One reason doctors are notoriously reluctant to testify in court is that their expertise is often put at issue, and experienced defense counsel through skillful cross-examination can attack their credibility. This can be avoided by close prosecutor-medical cooperation. Still another means of facilitating the presentation of testimony by medical personnel is to put them on call, rather than requiring them to wait hours in court until they are asked to take the stand.

3. *Citizen groups.* In many communities there is now a wide range of women's organizations and other citizen groups concerned with improving the community response to rape. These range from radical feminists to more traditional groups, such as the Junior League. Many groups may be able to help prosecutors in providing witness support persons and community education.

Where resources do not permit adding witness support staff in prosecutors' offices, citizen groups may have such trained persons available. They can assist victims in a variety of practical matters: providing information on the status of their cases; securing transportation and babysitting; arranging for time off from work for court appearances; accompanying victims to the hospital, to police and prosecutor interviews, to court appearances; and referring them to any necessary follow-up medical treatment or counseling. (See the Citizen Action Section.)

Joint education programs involving the prosecutor's office and citizen groups, preferably with police and medical participation, can serve to encourage rape reporting and help focus public attention on aspects of the court process that need greater funding or can be improved at the local level.

4. *Privacy and the press.* To preserve the victim's privacy, informal arrangements should be made to withhold the name of the victim in all but the most notorious instances. This is particularly crucial in light of the Supreme Court's recent decision invalidating a state statute that prohibited disclosure by the press of rape victims' names, even when the names were in the public domain.

SECTION 4

THE RESPONSE OF CITIZENS' ACTION GROUPS*

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*Research performed by Center for Women Policy Studies

CHAPTER X. INTRODUCTION

The so-called antirape movement began through the initiative of citizens. Its instigators were members of the women's movement who started in 1971 and 1972 to form groups to address the problem of rape. Efforts to help rape victims cope with their trauma were formalized into what came to be known as rape crisis centers. Gradually, other, more traditional, organizations have also undertaken rape-related projects. At each level of government, both legislators and administrators are now involved in the effort to control rape and to make the criminal justice system more responsive to the victims of the crime.

This section deals primarily with citizen action groups—a term meant to encompass feminist collectives, volunteer or service organizations, church groups, civic organizations, ad hoc committees, professional associations, social clubs, and others. It is also designed to be of use to government officials and their staffs, commissions, and task forces who might undertake to investigate, reform, or coordinate the way in which a state, county, or municipality deals with the problem of rape.

A third anticipated audience is made up of the various components of the criminal justice system that interact in the processing of a complaint of rape. It is hoped that information presented here will provide police, prosecutors, and medical personnel with an understanding and appreciation of the constructive roles citizens and government can perform in the effort to improve community response to the crime of rape and to its victims.

Four functions have been identified as appropriate for citizen action: (1) victim services, (2) public education, (3) catalyzing change within the criminal justice system, and (4) law reform. Since a complete "how to" approach for each of these is not feasible, it is assumed that a group undertaking any of these functions has or can obtain independently the basic skills with which to perform it. For example, this book cannot teach lobbying skills, but it can explain the issues involved in rape law reform, identify likely sources of support and opposition, and suggest strategies. Teaching basic counseling techniques is also beyond the scope of this book, but the particular needs of rape victims that can be met by lay persons, paraprofessionals, and mental health professionals are discussed.

When, in the spring of 1974, rape-related projects in the citizen sector were surveyed by the center for Women Policy Studies, it was with the expectation that many more would be located than the well-publicized few, and that the experience of these programs, however brief, could be used to construct guidelines for new groups with similar purposes.

Announcement of the project and a solicitation for appropriate groups to be included in this survey were published in major newspapers, women's magazines, feminist newsletters, professional journals, the underground press, and women's rights publications during February and March. A checklist was developed for use on the telephone with the wide variety of groups to be contacted. Each respondent was asked to supply the names of other relevant projects. Ultimately 60 groups were interviewed, most of these during May and June 1974.

Next, criteria were developed for selecting certain of these programs to be visited in order to gather more detailed information about their organization and functions, to observe their operation, and to meet key personnel. It was decided not to measure all the projects against certain standards, such as time in operation, innovativeness, scope or depth of activity, or apparent effectiveness. Instead, an effort was made to visit a variety of kinds of organizations (official and unofficial, collectives and national organizations, funded and unfunded, radical and traditional) in small towns, in cities, and in all areas of the country. Projects in existence longest, whose personnel or members had accumulated experience, were favored, but new projects with especially innovative approaches were also included.

Most of the selected sites were visited during June, July, and August, after interview techniques had been tested. Time spent at each project rarely exceeded half a day, but many cities had several citizen organizations impacting on the rape problem, and some had an individual or committee to coordinate these activities.

Citizen Action and Community Projects Contacted

*Bay Area Women Against Rape
Berkeley, California

Marin County Rape Crisis Center
Kentfield, California

L.A. Commission on Assaults Against Women
Los Angeles, California

L.A. County Commission on Human Relations
Los Angeles, California

*Rape Task Force of San Diego
San Diego, California

Harbor Free Clinic
San Pedro, California

*San Francisco Women Against Rape
San Francisco, California

*Denver Anti-Crime Council
Denver, Colorado

*Denver Victim Crisis Line
c/o Southeast Denver Neighborhood Services
Bureau
Denver, Colorado

*Rape Prevention Program
Department of Psychiatry
Denver General Hospital
Denver, Colorado

Prudence Crandall Center for Women
New Britain, Connecticut

Dade County Rape Task Force
Coral Gables, Florida

Hillsborogh County Stop Rape, Inc.
Tampa, Florida

*Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia

Women Against Rape
Champaign, Illinois

DuPage Women Against Rape
Clarendon Hills, Illinois

*Women United Against Rape
Indianapolis, Indiana

Women's Committee on Sex Offense
South Bend, Indiana

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*Denotes site visit.

Rape Relief Center
Louisville, Kentucky

YWCA Rape Crisis Service
New Orleans, Louisiana

Baltimore Rape Crisis Center
Baltimore, Maryland

University Women's Crisis Hotline
College Park, Maryland

*Passage Crisis Center
Silver Spring, Maryland

*Boston Area Rape Crisis Center
Cambridge, Massachusetts

Women's Crisis Center
Ann Arbor, Michigan

Everywoman's Center
Flint, Michigan

Rape Counseling Center
Neighborhood Involvement Program
Minneapolis, Minnesota

*NOW Task Force on Rape
St. Paul, Minnesota

*Sex Offense Services Committee
c/o Department of Social Work
St. Paul-Ramsey Hospital
St. Paul, Minnesota

Rape Crisis Center
Reno, Nevada

New Hampshire Social Welfare Council
Concord, New Hampshire

Junior League of Montclair-Newark
Montclair, New Jersey

Rape Crisis Center
Albuquerque, New Mexico

*Manhattan Women's Political Caucus
New York, New York

*Mayor's Task Force on Rape
New York, New York

*New York Women Against Rape
New York, New York

*NOW Rape Prevention Committee
New York, New York

*Chapel Hill-Carrboro Rape Crisis Center
Chapel Hill, North Carolina

*North Carolina Memorial Hospital
Emergency Room Rape Crisis Program
School of Medicine
University of North Carolina
Chapel Hill, North Carolina

Rape Crisis Center
Women Helping Women
Cincinnati, Ohio

Rape Crisis Center
Cleveland, Ohio

Women Against Rape
Columbus, Ohio

Women's Center
Rape Collective
Dayton, Ohio

Kent State Rape Crisis Center
Kent, Ohio

Toledo United Against Rape
Toledo, Ohio

Oklahoma County YWCA Rape Crisis Center
Oklahoma City, Oklahoma

Stillwater Personal Contact Service
Stillwater, Oklahoma

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*Denotes site visit.

Rape Relief Hotline
Portland, Oregon

Women's Crisis Service
Salem, Oregon

*Center for Rape Concern
Philadelphia, Pennsylvania

*Women Organized Against Rape
Philadelphia, Pennsylvania

*Pittsburgh Action Against Rape
Pittsburgh, Pennsylvania

Austin Rape Crisis Center
Austin, Texas

Dallas Women Against Rape
Dallas, Texas

Forth Worth/Tarrant County Task Force on Rape
Fort Worth, Texas

Northern Virginia Hotline
Arlington, Virginia

*Rape Relief
Seattle, Washington

*Sexual Assault Center
Harborview Medical Center
Seattle, Washington

Project Assist
Madison, Wisconsin

Rape Crisis Center
Madison, Wisconsin

Anti-Rape Council
Milwaukee, Wisconsin

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*Denotes site visit.

CHAPTER XI. FINDINGS ON CITIZEN ACTION GROUPS AND THEIR RESPONSE TO RAPE VICTIMS

Most of the information in this chapter deals with the genesis, purpose, organization, and operation of a relatively new entity—the rape crisis center. Readers are assumed to be less familiar with the work of such centers than they are with that of police, prosecutors, and hospitals. For that reason, the findings reported here provide more background information, explanatory material, and analysis than those pertaining to the companion handbooks that make up this report.

Based on conversations with approximately 100 women associated with more than 60 rape-related projects, a profile of rape crisis centers has been constructed. When the survey and site visits were conducted in the spring and summer of 1974, most of the groups contacted were in the planning or initial stages of their programs. The information, therefore, deals as much with theory as with experience. Still, patterns have emerged that make it possible to generalize about the problems and accomplishments of these fledgling groups.

Many of the issues of concern to all citizen action groups are discussed at length under Paragraph XIA, The Rape Crisis Center, and are only alluded to in the subsequent paragraphs titled Government and Community Task Forces (XIB) and Other Organizations (XIC). The latter category includes such women's rights groups as the National Organization for Women; women's social, service, professional, and church organizations; community agencies; and a midwestern phenomenon known as Women's Crusade Against Crime.

A. The Rape Crisis Center

1. *History.* The rape crisis center is a child of the women's movement. Centers are often spin-offs of a consciousness-raising group, a women's center, or a militant women's organization. The earliest groups formed almost simultaneously in the spring of 1972 in geographically diverse cities such as the District of Columbia, Chicago, Detroit, Philadelphia, Seattle, and Berkeley.

Their success in calling attention to their cause and the resulting proliferation of centers is probably attributable to the convergence of several factors. First, the women's movement had acquired a foundation of credibility and acceptability which the centers were able to build on. At the same time, both the news media and governmental bodies were beginning to deal with other problems related to sex—such as homosexuality, abortion, and birth control. In addition, no matter how seriously it is approached, the rape issue has two aspects—sex and violence—that rarely fail to interest, even titillate, an audience or reader.

2. *Goals.* Centers typically adopt one or more of the following objectives, which will be discussed further under the heading "Program":

- to provide supportive services to victims
- to reform institutions which deal with victims
- to educate themselves and the public on rape-related issues
- to reform the law

Centers with a feminist orientation are apt to have an additional goal—that of creating a context in which women help themselves and each other. They may earn the reputation of being antimale, antiprofessional, and difficult for more conventional groups to work with. It is important, therefore, to assess why achieving this goal is important to the groups that attempt to do so. As the Ann Arbor Center put it in its booklet, *How to Organize a Women's Crisis Center*, "What you do is less important than how you do it and how you treat each other."

Rape is perceived by feminists and many other women as the logical extension of the general violence of men toward women and the sexual, political, and economic exploitation of women by men. A rape victim who reports the crime puts herself in the hands of a series of police officers, doctors, prosecutors, and judges—all of whom are apt to be male. When these men respond negatively and accusingly toward her, they heighten the fear and resentment of men engendered by the sexual attack.

The women's movement has taught women that they can benefit from sharing their experiences and feelings with each other. A rape victim can be helped, for example, by warm empathetic communication with other victims. Furthermore, women need to be helped to help themselves rather than submit their problems to an authority figure in the person of a police officer, social worker, or chaplain. One reason rape is a traumatic event is because the victim loses control over her own body. The feelings of helplessness that result can be overcome in part by giving her the opportunity to regain control of herself, rather than by having someone else take care of her. The Ann Arbor group discusses this objective in its training materials under the title "Sisterhood vs. Dogoody Twoshoes," and contrasts the kind of support rape crisis centers can provide with more traditional forms of assistance.

3. *Organization, location, and affiliations.* The rape crisis center as an institution is evolving from small groups of women bound together by strong interpersonal relationships and ideology toward more formal structures. The earliest groups were begun by a few women who dedicated themselves almost exclusively to the cause. They operated as collectives, sometimes with rotating leadership or a steering committee. Typically, each woman was involved in all decision-making and every aspect of the program.

Many of these centers have now reorganized. The District of Columbia center explains in the preface to the new edition of their bulletin, *How to Start a Rape Crisis Center*, why they changed their structure. They found that with the influx into the center of women with less time to offer, having officers and committees was a more efficient way to operate. Other groups consulted expressed concerns that are well articulated in Jo Freeman's article "The Tyranny of Structurelessness."[1] Freeman concludes that the elitism arising in structureless groups creates more real powerlessness for other members of the group than does the democratic process used and abused in male-dominated institutions. Unlike the earlier centers, most groups forming in 1974 and 1975 have structured themselves with officers, bylaws, boards of directors, and committees. In many instances, membership dues and attendance at meetings and training sessions are also required. The experience of the Boston Area Rape Crisis Center runs counter to this trend, however. It is a 12-15 member group of volunteers that operates as a collective. The group functions effectively this way and does not wish to expand its membership or to organize along hierarchical lines.

Rape crisis centers may be housed in the basement of a private home or space donated by a YWCA, women's center, church, college, or community organization. While some groups have rented their own office space, lack of reliable funding often results in forced moves. Many groups prefer to keep their location confidential from the general public for reasons of safety and privacy for themselves and the victims they assist.

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[1] *Ms.*, Vol. 2 (July 1973): 76.

Universities and colleges have been resources for the rape crisis movement in providing founders, volunteers, facilities (health services and campus security), and funding. Eight of the groups surveyed are directly affiliated with universities. Fifteen are located in university communities and are heavily staffed by students. They also use university facilities and staff in their operations. Universities with some involvement in rape crisis centers include both small and large public and private institutions—among them Kent State, the University of Michigan, and the University of Texas.

4. *Funding*. To some extent the rape crisis center has become a victim of its own success in that its resources almost always fall short of demand. The earliest groups saw themselves as women helping women on a one to one basis, pointing out inequities in the criminal justice system, making occasional public appearances, and producing educational literature. They believed that by charging nominal fees for speaking and for written materials they could pay out-of-pocket expenses.

This expectation did not take into consideration the enormous interest they were stimulating in the crime of rape. Soon, hotlines set up for calls from victims were occupied instead with calls from reporters, local organizations wanting speakers, and students writing papers. Center volunteers, usually students or working women, lacked time to respond to demand for services and tend to concentrate on the internal organizational problems of rapid growth. Most groups found they needed some paid staff and a budget for operating expenses, so they decided to seek funding.

To date, few rape crisis centers have obtained grants to support their work. Funding for those who have obtained it usually covers rent, supplies, and a small number of personnel, leaving a heavy reliance on volunteers to carry out programs. Police departments, hospitals, prosecutors' offices, mental health agencies, and crisis intervention centers are all competing with rape crisis centers and with one another for local funds. But the rape crisis center is disadvantaged in this competition because most grantors prefer to deal with established institutions and professional credentials. Most centers are neither incorporated nor tax exempt, so they are even less attractive as grantees. Some have surmounted this problem by utilizing other organizations, such as a counseling center or a YWCA as funding conduits. Others have become, or were set up as, adjuncts to larger funded projects. For example, Women Organized Against Rape (WOAR) in Philadelphia receives aid from the Center for Rape Concern, and a rape crisis center forms part of the Neighborhood Involvement Program in Minneapolis. Others have prevailed upon the local YWCA, church, or another community group to donate office space, supplies, staff personnel, printing services, and small amounts of money.

A problem that all rape-related projects encounter is a reluctance of funding sources to deal with any issue involving sex. This inhibition is likely to be overcome only when the problem has been thoroughly aired and legitimized through research or public discussion.

From the point of view of feminist groups, rape creates social and psychological problems for women that warrant the expenditure of tax exempt or public money. But little private or public financial support has been made available to the women's movement, particularly to anti-establishment or "alternative" organizations, which rape crisis centers are likely to be. This is in sharp contrast to monies made available to other alternative programs, such as those for runaway youth, drug abuse, or free clinics. Women's colleges and traditional women's organizations, such as the Junior League, receive large amounts of money, but it is usually for projects unrelated to the status or welfare of women as a class.

At least one rape crisis center has refused a grant that was contingent upon the keeping of records and reports, including the identification of victims. The requirement was attached in order to make evaluation of the program possible, but the center, Bay Area Women Against Rape (BAWAR), decided it could not operate without protecting the anonymity of victims who contacted them. Rape Relief in Seattle and Pittsburgh Action Against Rape (PAAR) have been able to develop record-keeping systems that protect the interests of the victim but also meet the needs of the government. Law enforcement funds are also unacceptable to some groups because they feel it is "dirty money" or fear it could subject them to scrutiny by the FBI, the CIA, or the police.

Finally, some centers fail to raise money when their proposals are subjected to a cost-benefit analysis. In small communities where there are few reported rapes, it is difficult for funding sources to justify the expenditure of even modest sums for programs directed exclusively toward victims of this crime. Even in large cities it is less expensive to add to the existing budget of a hospital or other institution than to set up a new organization.

5. *Personnel.* Most rape crisis centers are operated by and, for the most part, serve young, middle-class, white women. Typically, volunteers are friends who have known each other in a consciousness-raising group, a women's center, a national women's organization, or at college. Most are between the ages of 20 and 40 and are college-educated or students. Some are professionals in the health, social service, or teaching fields.

Rape victims compose only a small percentage of the women who volunteer their time, although about half the groups have the input of rape victims. Only about half the groups refer to themselves as "feminists." This may be because there is no generally accepted definition of that term, so people are hesitant to apply it. It also may be that this word is considered too limiting for centers striving to become more inclusive and broadly based.

There is a conspicuous absence of women who are members of minority groups on the staffs of rape crisis centers. Efforts to recruit them in the states of Washington, Texas, Oregon, and California have been largely unsuccessful to date. Women who are poor, work full time, or have families cannot afford to volunteer. Because there are few minority women working at the centers, and because the centers are unknown in minority communities, few minority women go there unless they are specifically referred by the police or hospital staffs.

Consistent with the philosophy that women need to organize themselves to help each other in a male-dominated culture which is insensitive to women's needs, men are seldom accepted as volunteers in rape crisis centers. Where there are male counselors, they work primarily with men related to the victim, not the victim herself. In Weld, Colorado, a male juvenile services worker has, in his official capacity, joined forces with the rape crisis center. An increase of this type of cooperation will make it possible to test the validity of the "women only" philosophy of the rape crisis movement.

In Philadelphia a group known as Men Organized Against Rape (MOAR) has operated a hotline for male friends and relatives of rape victims since February 1975. It also distributes educational materials on how male friends and relatives can help a rape victim. MOAR has conducted training programs for other groups from North Carolina and Delaware and Atlantic counties in New Jersey.

Centers report difficulty in maintaining adequate staffing, particularly if 24-hour, 7-day-a-week telephone coverage is attempted. Scheduling of this sort requires four times the personpower as the normal business week. Most centers have 8 to 30 trained workers. Groups that rely heavily on student help are shorthanded during the summer, holidays, and exam periods. The drop-out rate is especially high among volunteers who work directly with victims, because of the emotional stress and because of the heavy demands apt to be made on their time.

Throughout this section, reference will be made to counselor/advocates, a term invented to describe persons who act simultaneously as counselors and as advocates in the ways described in the section on programs. Even when they work in teams, which they often do, each is usually trained to perform both functions. Other center volunteers may not work directly with victims at all. They might be administrators, public speakers, lobbyists, or persons skilled at working with police, prosecutors, or hospitals.

Provision of a variety of services requires a constant cadre of trained volunteers. Some groups, including Sacramento, Pittsburgh, and Champaign (Ill.), allow women to become specialized in particular kinds of work. They believe that this system tends to minimize volunteer dissatisfaction and dropouts. Most centers, however, do not have a large enough or stable enough staff to afford specialization. In addition, some centers report that many women continue to volunteer *because* of the opportunity to learn a variety of skills. The center in Cambridge has a core staff of 12 to 15 women who are trained to perform all the tasks involved in the center's operation. They like the flexibility this gives to both the individual workers and to the group.

Many of the women who have founded rape crisis centers view themselves as political activists or community organizers, rather than as volunteers who perform social services. They may, in fact, reject as economic exploitation the concept of women volunteering services that they feel the government ought to provide. Some would remain as counselors or administrators in rape crisis centers if they could be salaried, some would work for other institutions to help rape victims if paid, but others prefer to move on to new issues. For all these reasons the availability of "new blood" remains vital to the volunteer rape crisis center.

6. *Recruitment, screening, training*. Recruitment of volunteers is seldom done in any systematic way by the centers, despite the fact that most want to expand their numbers. New members are usually recruited from among friends and acquaintances. The homogeneity of the resulting group has the advantage of reducing conflict and creating a sense of cooperation among staff members, but it does not contribute to making the center a service for, nor a voice of, a broad spectrum of women. Maintaining a large, diverse resource list helps ensure that an appropriate person is available to meet the needs of a victim, whatever her life-style or background. A few centers prefer to operate with a small, experienced staff that has established good relationships with the community.

A few groups that have experienced high drop-out rates among volunteer counselor/advocates are beginning to screen applicants before investing time in their training. For most centers, however, to reject a woman's services would be antithetical to their purpose of having women help themselves and each other.

Training sessions are conducted by virtually all rape crisis centers to prepare volunteers to deal with those emotional, medical, legal, and political aspects of sexual assault that will be relevant to the victims they seek to counsel. There is usually a core staff who trains new volunteers. Frequently they have educated themselves with available literature and through exchanges with other rape crisis centers or institutional personnel who deal with victims of sexual assault. Mandatory training ranges from two to six initial sessions, with some groups also requiring monthly continuing education programs. In addition there may be periodic group meetings with a supervisor so that volunteers can receive help with problem cases, as well as moral support.

Veteran rape crisis centers, such as those in Ann Arbor, Madison, the District of Columbia, Seattle, New York, Berkeley, and South Bend, have developed training manuals now widely used by other centers. These manuals contain the information necessary for a volunteer to serve as a rape victim counselor/advocate, to be a public speaker, and to intervene with the relevant institutions. Each group must adapt the materials to include information about their own community practices. Training materials may also include information concerning self-defense, venereal disease, birth control, and pelvic examinations.

Training techniques include lectures, role playing between volunteers and trainers, empathy training, and some basic counseling techniques such as listening, feedback, responsiveness, and guidance. Professionals from the fields of mental health, medicine, law, and law enforcement serve as trainers in about half the centers surveyed. Sometimes they are members of the center and also participate as trainees. Formal training sessions are usually followed by "on the job" training with an experienced counselor or public speaker. Learning to be an effective volunteer in a rape crisis center is a time-consuming process, as is the work itself. The realization of this fact causes many trainees to drop out. Others are not comfortable with some training techniques, such as role playing, particularly when group members know each other well.

An innovative training plan in Baltimore County included a mock rape trial with trainees playing different roles to become familiar with court procedures, the intricacies of the law of evidence, and the situation of both the victim and the defendant. The center in Sacramento requires volunteers to participate in self-defense, gynecological self-help, and first aid workshops. This training is often open to nurses, social workers, and detectives who wish to increase their awareness and take their knowledge back to their jobs and other personnel. This cooperation has also encouraged referrals among the center, the hospital, and the police department.

In addition to teaching the volunteer to assist the victim, training prepares her to cope with her own feelings. Counseling and victim advocacy are emotionally charged and physically draining experiences. Volunteers must learn their personal limitations; otherwise, feelings of frustration and inadequacy can cause the worker to withdraw from the program. Centers in Boston and Sacramento have organized periodic dialogues between counselors and mental health professionals to provide case supervision and an opportunity for counselors to express their feelings about their work. This practice seems to reduce the number of workers who drop out. Volunteer turnover causes a center to engage in constant training, which diverts resources from the center's mission of aiding rape victims.

7. *Publicity*. Publicity is essential if a rape crisis center is to meet its objectives: providing services to victims, changing procedures in criminal justice agencies, public education, and legal reform. Services for rape victims must be advertised if they are to be used by the general public. In Seattle, the public transit company donated advertising space on the outside of the buses to publicize the hotline number. In New York City, the Mayor's Task Force implemented a subway poster campaign. Other groups using posters have found that attractive ones were frequently stolen. Similarly, stickers placed in phone booths were torn off. Public service announcements on radio have been utilized. For example, when centers in Dayton and New York City ran marathon public service announcements, the number of calls they received from rape victims increased dramatically.

Public education programs rely heavily on the press and the telecommunication media to deliver their message. Feature stories and talk shows provide good forums for the dissemination of information and ideas about the crime of rape.

Rape crisis centers that do not have access to the policy-making levels of government and private institutions must use the press to confront police chiefs, district attorneys, and hospital administrators in order to improve the treatment of rape victims. Although access to newspapers, radio, and television may be difficult for some centers, especially in areas where there is little concern about the crime of rape, most groups reported no difficulty having their complaints about police, court, and hospital procedures published.

8. *Program*

a. *Education.* The educational programs of rape crisis centers usually have overlapping objectives: (1) self-education, (2) information dissemination, and (3) encouraging attitudinal change.

The first groups that formed had to be resourceful, because there was little literature or existing expertise on rape or rape victims from which they could learn. Both the District of Columbia and Detroit centers published handbooks in 1972 to tell other groups why and how they organized. These served as manifestos, as well as practical guides. Further exchange of ideas has gone on through pamphlets, newsletters, articles, and books—resulting in a uniformity of goals, programs, and ideology. This effective communication network has been strengthened through regional conferences and visiting each other's projects. The District of Columbia-based Feminist Alliance Against Rape (FAAR) has established a clearinghouse and newsletter for feminist groups to further accelerate communication.

The dissemination of information on how to prevent rape and what to do when you are raped is an important function of a rape crisis center; although, it may also be done by police departments through public speaking and the distribution of pamphlets. Programs in rape prevention and self-defense range from common sense environmental safety tips on locks and lighting, to karate and judo instruction.

The law and evidentiary rules in several states still require evidence that a woman physically resisted her attacker to show that she did not consent to the sexual act. Some centers believe a woman should not fight a rapist because struggle will invite further brutality. Other groups teach women tactics to surprise attackers for time enough to escape. A great deal of controversy exists about self-defense, largely because so little is known about how rapists are apt to respond to resistance.[2] It is agreed, however, that a victim should be supported in her decision, whether it is to struggle to the utmost or to submit when it is no longer reasonable to resist.

There is a general agreement that a victim's response to assault will be consistent with her personality and governed by her perception of her advantage relative to that of her attacker. A woman can be trained to be aware of her own capabilities and to reasonably believe she can control her situation. But this kind of self-awareness and confidence is not learned in a brief training session. For this reason some groups, including the National Organization for Women (NOW), advocate better physical education programs for school-aged girls and that women take the time for a thorough self-defense course. Nationwide, NOW rape task forces are offering self-defense workshops and courses in public schools and other community-based agencies.

Perhaps the most important objective of most centers is to destroy beliefs that women invite and enjoy rape; that they can't be raped if they resist; and that all rapists are "sex maniacs." This process is called "demythologizing" the crime. Such myths are thought to be responsible for the way police, prosecutors, doctors, nurses, judges, juries, husbands, parents, and the community respond to the victim. They also underly the victim's own feelings that she is "guilty," "dirty," or "ruined." Destroying these myths is a necessary precursor to the reform of law enforcement and health care systems, which is one of the three major goals of rape crisis centers.

Some groups wish to go further and demonstrate that rape is part of a pervasive pattern of violence against women in our society and that it is the logical extension of generally accepted sex roles. This knowledge can serve a victim as a psychological defense against internalizing the trauma. It also provides an external outlet for her anger, so that it can be used constructively in fighting societal attitudes. These beliefs are often conveyed to victims as part of the counseling process, which will be discussed later.

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[2] An article by Dr. James Selkin in *Psychology Today* (Jan. 1975), recommending immediate resistance appears to have increased the controversy rather than resolved it.

The means for disseminating information and encouraging attitudinal change are numerous. Virtually all rape crisis centers either accept requests for speaking engagements or actively seek them with local organizations and schools. They usually cover all the subjects discussed above and encourage discussion, using the opportunity to distribute literature and publicize their services. Most groups report positive response to their message.

TV and radio discussion shows are becoming increasingly interested in rape as a topic and in rape crisis center personnel as discussants. In addition, a few crisis center women have consulted with persons making films, videotapes, and radio programs—to be aired to the general public or to specialized audiences, such as the awardwinning WCBS New York[3] and WHAS Louisville radio series on rape. Most groups have found that media access has been the most helpful method of meeting their educational goals. An increasingly popular form of communication is guerilla theater, where women act out the plight of the rape victim in presentations staged in public places or theaters.

Literature, especially pamphlets and brochures telling how to prevent rape or what to do if raped, have been produced by groups that could afford to do so. The Queen's Bench Foundation, an organization of women lawyers and judges in San Francisco, provides a half-hour video tape in Spanish as part of its educational program. Written, directed, and acted by Latinas, it is intended to address the myths and stereotypes in the Latin community regarding rape and the role of women.

Centers have sometimes provided information from their experience to writers of books on rape and have tended to resent the fact that the profits from the books are not being reinvested in the antirape movement. Of the recent books on rape, a few have been written by women affiliated with the antirape movement. Among these are: *Rape: Victims of Crisis*, by Burgess and Holmstrom, and *Rape: The First Sourcebook for Women*, by the New York Radical Feminists.

b. *Reform of law enforcement and health care systems.* The fact that rape victims who report the crime to police or go to a hospital for care are apt to be treated with skepticism and lack of compassion is a major motivating force behind the rape crisis center movement. Most centers make communication with police and hospital personnel their first order of business.

Their requests to law enforcement agencies include having more women police officers and detectives, sensitizing personnel to the needs of victims, tailoring police questioning to include only legally relevant information, and getting permission for a rape crisis center advocate/counselor to accompany the victim through processing. Hospitals are asked to examine the woman without delay, to have knowledge of and correctly perform both forensic and prophylactic procedures, to explain these thoroughly to the woman, and to allow a center advocate/counselor to remain with the victim in the emergency room and in the examining room if the victim wishes her to.

Prosecutors' offices are asked to keep rape victims advised of the status of their cases, to prepare victims psychologically for cross-examination at trial, and to maintain as much continuity as possible between the victim and one prosecutor. Some groups ask judges to be more sensitive to the inhumanity of certain evidentiary rules and to curtail them in the courtroom.

All law enforcement organizations and many hospitals are public institutions and, as such, should be responsive to citizen action. However, most have not been receptive to the requests of rape crisis centers. This is perhaps not remarkable when one considers that (1) the requests were often couched as demands and were, as such, poorly received; (2) the changes suggested often required a resource-consuming revision of systems and protocols, or fundamental attitudinal change in key personnel; and (3) most rape crisis centers do not have the clout to force these reforms.

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[3] Mary Gay Taylor, Producer, "Rape, the Law and You," WCBS Radio, New York City.

Centers that have built the best working relationships with police, hospitals, and prosecutors seem to have done so through the cooperation of a sympathetic person within these offices, especially nurses and detectives. When lines of communication have been opened, changes have been made and cooperative efforts initiated. These efforts include using center volunteers for training police, prosecutors, and medical personnel and having such personnel refer rape victims to the rape crisis center for information and services. Such cooperation has been undertaken by centers in Cambridge, Mass. and Salem, Oregon. The Ad Hoc Citizens' Committee on Sexual Abuse in Chicago has developed good relationships with law enforcement and health officials by maintaining a low profile and working slowly and painstakingly on a one-to-one basis with representatives of these groups.

Where good relationships have not been established, the rape crisis center has had to resort to embarrassing law enforcement and medical facilities into compliance, through the political process and through the press. Elected officials, such as mayors, city council members, sheriffs, and district attorneys, are usually approachable and sometimes willing to intercede with others. They tend to take more seriously requests made on the public record, however, than those made in private.

The press has been willing to publish reports or allegations of mistreatment of rape victims. The public has been appalled to learn how humiliating and futile the prosecution of a rape case can be for a victim. High public indignation generated by this kind of publicity may lead to needed reforms, but it also can have the effect of discouraging victims from reporting rapes to the police. The consequence is to further reduce the rate of reports and make it more difficult to apprehend and convict rapists.

Centers in communities where the treatment of victims is particularly bad or where the conviction rate is low are not troubled by the fact that adverse publicity about police, hospitals, or prosecutors might deter reporting of the crime. They believe that a woman who has been sexually assaulted should not be encouraged to subject herself to further abuse at the hands of the criminal justice system. Some groups advise women not to report rape. Most tell a victim what she can expect to have happen to her if she does report, but do not attempt to influence her in making a decision which they feel is rightfully hers. The victim's right to self-determination is in fact a basic tenet of most centers.

A type of program that is usually termed "courtwatching" has become a popular method of monitoring the trials of rapists. A victim advocate or other volunteers attend the trial to observe the behavior of attorneys and the court toward the victim and whether the woman is unnecessarily abused by the criminal process.

Some courtwatchers understand well the principles and procedures of a criminal trial in their state. They are alert to the rulings that the judge makes regarding the admission of evidence and the scope of cross-examination, and they scrutinize the court's charge to the jury. Other courtwatchers concentrate on the demeanor of members of the court and their apparent attitude toward the victim. Courtwatching is carried out in Seattle, Los Angeles, Indianapolis, and other cities. In Philadelphia and Toledo, center volunteers have presented their complaints to judges, prosecutors, and to the press. Courtwatching can also result in legislative proposals.

Recently women activists around the country have begun to pack courtrooms where rapists are on trial. Courtwatching is but one of their purposes. They wish to lend moral support to the complaining witness, but their presence can be intimidating to the defendant and his attorney and usually does not go unnoticed by the jury. The impact of their presence on the outcome of trials is not known.

An outgrowth of the efforts of rape crisis centers to change procedures of the police, hospitals, prosecutors, and courts has been the realization that many objectionable practices are consequences of the law on rape in their jurisdictions. For example, the fact that police "unfound" many reports, or that prosecutors plea bargain rape cases to lesser offenses, may be the result of the virtual impossibility of obtaining a conviction under state law because of corroboration requirements, admissibility of the complainant's sexual history, or mandatory high sentences for rape.

A number of rape crisis centers have, consequently, joined with other groups to draft new rape legislation and lobby for it. Centers have engaged in or supported such action in New York, California, Michigan, Iowa, and Florida, among other states. The legal issues to which they most often address themselves and the resolutions reached in some states are discussed in Appendix IV-A.

c. *Supportive services to rape victims.* Specific services available through most centers include briefing the victim on police and hospital procedures, assisting in meeting immediate personal needs, limited follow-up counseling, and advocacy-related services. Not all centers perform all services, but the format described below is typical of most.

These services began as a support system predicated on the belief that peer companionship and empathy with the victim would allay her anxieties, guilt, and the emotional trauma of the rape. There was no existing body of knowledge about psychological consequences and appropriate treatment for rape victims for centers to draw upon. Consequently, they learned largely from experiences of rape victims about the kinds of services that might be most beneficial. Many rape crisis centers believe that educating the rape victim on the role that society and the law enforcement system play in her problems will help her recover from the attack. It is also believed that if the center serves as a buffer between the victim and criminal justice agencies, any negative impact on her will be reduced, and her legal and personal rights will more likely be protected. Thus, center personnel serve not only as crisis counselors but also as "advocates" for the victim as she proceeds through the criminal justice process.

(1) *Hotline.* Most centers attempt to provide 24-hour-a-day hotline service so that a victim can have contact with a counselor immediately following the rape. The alternatives to direct coverage of the hotline are: an answering-referral service, a system in which the volunteer carries a "beeping" device, telephone switching systems, or providing a community's general crisis center with the names of on-call counselor/advocates. Because these alternatives may cause a victim to make more than one call or to wait for her call to be returned, they may discourage her from continuing to seek help.

The hotline services may be for information and referral, as in New Orleans, or a prelude to a personal contact or future telephone counseling. Centers average no more than three conversations with each victim who initiates contact solely by telephone. Women raped in the past, as well as friends and families of victims seeking advice for themselves or the victim, may also contact the center through the hotline.

The counselor or on-call volunteer talks briefly with the victim to determine where she is, what has happened, and what kind of help she needs. The counselor provides empathetic listening, and the victim is further encouraged to communicate by the counselor's feedback of what she perceives the victim's situation to be. She attempts to restore the victim's self-confidence and diminish her feelings of helplessness by encouraging her to make necessary decisions about communications with family or friends, police reporting, and medical treatment.

The victim is usually encouraged to go to the hospital, police, or home on her own. The counselor will meet her there, if requested, and if the center is adequately staffed to permit this. Volunteers work in teams in some places, such as South Bend. Police are called only at the request of, or in agreement with, the victim. If the victim does not wish to have the counselor meet her, the telephone contact focuses on immediate steps the victim may take. The counselor provides her with the necessary information to make those decisions. The victim frequently remains anonymous. Some do not wish any immediate or follow-up counseling.

(2) *Counseling.* In-person rape crisis counseling usually begins with a meeting set through a telephone request from a victim directly, or through police, hospital, or family. Few groups provide transportation or go to a victim's home late at night, for their own safety. Once with the victim, the counselor remains with her through the medical and investigative procedures, providing information regarding the pelvic exam, measures that should be taken against venereal disease and pregnancy, and what the police need to know and why. A friendly, supportive relationship is provided. The counselor will also talk with family or friends, calming them and allaying their anxieties, some of which may be detrimental to the victim.

The counselor remains with the victim until her immediate needs are met. These may include transportation; housing, if she does not wish to return home or be alone; prescriptions to be filled; notification of family; and scheduling of follow-up services.

Most centers attempt to initiate another telephone contact with the victim within 48 hours, but some are not able to follow through because of staffing shortages. The purpose of a follow-up call is to continue supportive counseling, assess the needs of the victim, and make appropriate referrals to meet medical or emotional problems. Many victims experience a delayed emotional reaction to rape—so that an outreach phone call may reach them when they feel more in need of and are more responsive to counseling than they were immediately after the assault.

In an effort to be available to victims after the immediate crisis has passed, some centers have attempted to hold scheduled or spontaneous group discussions where rape victims can talk with each other, assisted by two rape crisis center facilitators. The victims are notified of these groups, but typically few attend, and the programs are not notably successful. Rape Relief in Seattle, however, has reported a positive result from this technique.

Staff meetings at some centers are often used for discussing individual rape victim problems, difficulties encountered by the counselor, and projected plans for that victim. Few centers have been able to offer consistency either in availability of counseling services or in the availability of the same counselor.

In comparing the counseling services provided by rape crisis centers with the broad spectrum of possible mental health services, it is significant that all centers agree that their programs are not intended to provide long-term or intensive psychotherapy for rape victims. They are simply designed to provide immediate, temporary support and to ease the way of the victim through the trauma. Rape crisis centers maintain that peer counselors ideally serve the immediate needs of rape victims.

The peer counseling concept is not, of course, an innovation of the women's movement, although it is used effectively there. Rehabilitated drug abusers have been considered excellent counselors of other abusers because of their unique comprehension of addicts' personality disorders and relationship to society. Although rape victims make up only a small percentage of center volunteers, their impact on other women who wish to be counselors is immense. It is also believed that women have an empathic understanding for each other's problems of sexuality, powerlessness, and family relationships.

In the instances of drug abuse as well as rape victim counseling, when nonprofessional people began to take specific mental health and societal concerns into their own hands, considerable alarm was registered among mental health professionals. However, many professionals have come to agree that they have developed no special theory of treatment best suited to rape victims, and that it is in the best interest of their profession to participate in what is becoming a rapidly spreading counseling movement.

Although there is consensus that immediate crisis intervention counseling is needed, there is confusion and ambivalence among both professionals and paraprofessionals about the degree of emotional support and counseling required to facilitate a victim's adjustment or to prevent the development of psychological or behavioral problems resulting from the rape. The Medical Society of the District of Columbia in a report of its Ad Hoc Committee on Sexual Assault Victims concluded that the trauma of rape is so serious that professional psychological help should be immediately available. On the other hand, feminists tend to believe that it is detrimental to suggest to a victim that she needs professional help unless there is some indication she cannot cope with the reality of the assault or its consequences. They believe most victims simply need a sympathetic and accepting listener and enough information to enable them to make decisions.

Rape crisis center counselors usually believe they can tell when a woman needs help that they are not prepared to give. Some have professional volunteers they can call for advice, and most have lists of philosophically and personally acceptable professionals to whom they can refer cases. In Salem, Oregon, professionals remain on call in their offices one hour per evening for consultation and emergency help. Many psychologists and social workers volunteer to train and supervise lay counselors and become active, valuable, and accepted personnel of the rape crisis center. The center in Cambridge reported that the utilization of professionals in this way is an excellent educational technique and stabilizing influence for the counselors.

There remains, however, sharp resistance to the use of salaried mental health professionals as rape crisis intervention counselors. It stems in part from the belief of rape crisis centers that professionals as a group are not more informed about the psychological aspects of rape and, in fact, have learned much of what they know from the rape crisis movement. In addition, the women's movement has a generally skeptical attitude toward most psychiatric treatment, which they view as reinforcing the oppression of women in traditional roles, including that of the seductress. Finally, rape crisis centers that are attempting to find financial support for their programs resent having to compete with professionals who would not have been interested in the problems of rape victims had they not been educated by the rape crisis movement.

(3) *Anonymous reporting.* Helping the victim decide whether or not to prosecute her assailant is a principal task of the counselor. Almost half the centers encourage police reporting; others prefer to remain neutral, allowing the victim to weigh the pros and cons of her involvement with the criminal justice system. A small number of centers advise the victim not to prosecute because of her probable humiliation if the case goes to trial. The local police are generally advised of the position of the center in this matter.

In Boston, Seattle, and other cities, victims who do not wish to report the crime may arrange for an anonymous report to be filed with the police by the center. This is often referred to as a "third-party reporting" system. (See handbook on police procedures.) Police are concerned that groups which receive and relay such reports discourage victims from prosecuting. And they feel that, at best, this activity helps them only in gauging how many rapes are actually taking place, but is of little use in apprehending or prosecuting rapists. Some victims in Seattle, however, who would not have reported did so after first giving anonymous reports to counselors. In Denver, the option of anonymous reporting is not offered by counselors until it is clear that the victim will not talk with police.

(4) *Victim advocacy*. The advocate is usually, but may not always be, the same person as the counselor. While attending to the personal needs of the victim, she will also intervene with criminal justice and medical personnel when she feels the victim is not being treated properly. Following initial medical and investigative procedures, the advocate maintains telephone and personal contact with the victim throughout the lengthy prosecution process. She may attend interviews, preliminary hearings, and the trial with the victim. In the Colorado Springs area, one local police department telephones the rape crisis service so that a volunteer can be present with the victim during police interviewing. Another department allows the volunteer to be present at the interview if she has accompanied the victim to the interview. She may keep abreast of the status of the case, keep the victim informed, and intervene when it is evident that the case is not being handled properly. In some instances the victim feels the need for support immediately prior to her trial, and makes her first contact with a center at that time. Chicago Legal Action for Women provides advocates to help prepare victims for court. In addition to explaining to her what she can expect in court, the advocate also arranges for her to meet with the assistant state's attorney who will be representing her. The advocacy service can be provided most effectively where the rape crisis center enjoys a good relationship with police, hospitals, and prosecutors, and an advocate can accompany the victim in all her contacts with these agencies.

About 80% of the centers surveyed had attempted to gain cooperation and assistance from these agencies in aiding the rape victim. More than half of the centers in that 80% described good and improving relationships with the police. About the same proportion of centers described fair to poor relationships with hospitals, citing resistance to the presence and intervention of the center volunteer and resistance to any changes in the hospitals' own practices as problems. Prosecutors appear to be largely unresponsive and negative to the role of a lay advocate for the rape victim.

Many centers continue to act as advocates for the victim despite negative agency response, because the reaction reaffirms the center's view that the victim does indeed need support and representation in these institutions. Individual employees may act according to their own attitudes, rather than according to the policy of their employers. Consequently, some rape victims may be treated sensitively, while others are not by different people in the same institution.

(5) *Other services*. Victims of any crime may need help in their personal lives because they have been injured, because they are afraid, or because they cannot afford to lose time from work or be away from home long enough to participate in the criminal justice process. Some centers are able to provide transportation to doctors' offices, baby sitters, safe places for rape victims to sleep until they are no longer afraid, and other services of a logistical as well as a personal nature.

9. *Utilization of rape crisis center services.* The vast majority of women who are raped do not receive assistance from rape crisis centers. Most do not seek help from anyone because of guilt, embarrassment, or fear of police and institutional treatment. A majority of the centers surveyed believe that most women are unaware that a rape crisis center exists in their community and that minority women are especially unlikely to know of the existence of a center; since as a group they have not been as involved in the issue of rape as have majority women. Even women who know about a center may reject its services because they view the group as too radical or otherwise inappropriate for their needs.

In about half the communities surveyed, the police and hospitals never refer women to a rape crisis center. This understandably has a great impact on the number of victims serviced. On the other hand, in Philadelphia, where the center is located in the hospital, more than 800 victims were assisted during its first year.

All too often victims are unable to contact a center because its phone is not being answered. The location of most centers is not publicized and is often difficult to determine. Sometimes there is no office, and services are provided by volunteers from their homes. Outreach programs have generally been ineffective. To an extent, the underutilization of rape crisis center services can be attributed to their newness as social service institutions. This was demonstrated in Seattle, where the crisis center was contacted 10-15 times a month at the outset, but the volume later increased to 45-55 calls per month. The Texas Rape Prevention and Control Project conducted a joint outreach program in San Antonio with the Business and Professional Women's Club. The seminar was bilingual in its presentation and materials and was directed at Chicanas. Another example of minority outreach activity is found in Chicago where the League of Black Women has set up the South Side Rape Action project.

Most calls to rape crisis centers are not from recent victims but are requests for information, referrals, speaking engagements, or even crank calls. Only a few groups have been successful in delivering services to significant numbers of victims; many have given up attempting to provide more than information; and others are trying to expand their services to women victims of all violent acts.

B. Government and Community Task Forces

Another kind of organization being used successfully in the antirape movement is the government or community task force. Its primary purposes are to investigate the ways that rape cases and victims are handled and to make recommendations for improvements. It often studies the law on rape, as well. Because it is usually an official or quasi-official body, its conclusions and advice may be more apt to be heeded than those of a rape crisis center undertaking the same function. On the other hand, because it is likely to disband after a report is issued, it does not have the capability to follow through on its recommendations in the way that a rape crisis center does.

Most task forces have been set up by a governmental body such as a city council or a commission on the status of women, and some, such as those in San Diego and Fort Worth, were created through the initiative of private citizens. All are typically composed of representatives of the police, sheriff's office, hospitals, medical associations, health and mental health departments, district attorney's office, and other community agencies—such as Planned Parenthood, YWCA, and Family Service agencies. Usually, there is also a representative from the rape crisis center or an activist women's organization.

Task forces that hold hearings to determine how community agencies behave toward rape victims accomplish an educational as well as an investigatory purpose. Similarly, task force reports released at press conferences have an impact on the public consciousness as well as a message for the governmental body to which their work is submitted. In both these ways, the task force carries out the educational function of a rape crisis center on a temporary basis. The third major mission of a center—direct services to rape victims—is, of course, an entirely inappropriate function for a temporary group.

Task forces have been formed in a number of major cities, including New York, Los Angeles, Seattle, Chicago, Baltimore, Buffalo, and the District of Columbia, as well as in many suburban areas. Most, like the one in the District of Columbia, have studied rape laws and victim care in their communities, made a report and recommendations, and disbanded. A few, most notably the Mayor's Task Force in New York City, continue to perform a coordinating function among groups represented on the task force as their recommendations are put into effect.

There is seldom adequate staff support for the task forces. The community agencies donate the time of their representatives, and others serve as volunteers, frequently having to take leave from paid positions to attend meetings.

C. Other Organizations

The three basic functions of the rape crisis center, which, for the sake of brevity, can be referred to as education, reform, and services, have each been adopted by other kinds of organizations. These groups, unlike the rape crisis centers and the task forces described previously, have purposes broader than and unrelated to the problems of rape victims.

They usually have more financial and human resources than do rape crisis centers, and they limit their activities to those at which they are experienced. Some groups specialize in the delivery of services, others provide educational programs, and still others work actively for institutional or law change. A few combine two of these objectives.

1. *Services.* Just as 1972 was the year in which rape crisis centers seemed to spring up spontaneously around the country, 1974 marked the advent of interest in rape victims from social service and mental health agencies. Our survey disclosed about 20 organizations, including the YWCA, Planned Parenthood, Family Service agencies, health clinics, schools, churches, neighborhood service groups, and health and welfare councils, in the preliminary stages of providing counseling services for rape victims.

The YWCA has been particularly responsive to requests from fledgling rape crisis centers for support. It has rented or donated office space and switchboard service and given office supplies or staff time to help centers in a number of cities. The YWCA has participated in the planning and operation of some centers and has been represented on official task forces.

Most of these larger organizations have the advantage of funds to support a professional or paraprofessional staff, have established relationships with hospitals and police, and are known to a significant number of people in the community. In many instances they could offer services to rape victims without seeking additional funding, simply by reallocating their resources. Nevertheless, all those organizations polled realized the need to provide additional in-service training to sensitize their staffs to the problems of rape victims and to their feelings about counseling sexually assaulted women. The ability of these agencies to provide counseling tailored to client needs, rather than limiting their work to crisis intervention, is of particular value.

The interest of service organizations in rape is sometimes the outgrowth of their professional assistance to rape crisis centers. In other cases it is due to their own experience with victims, whether they have sought help because of the rape or have come with a problem seemingly unrelated to the sexual assault. No doubt publicity concerning the plight of rape victims has also contributed to the new interest on the part of service agencies.

2. *Reform.* Two very different kinds of organizations are active in the efforts: to change procedures used by hospitals and the criminal justice system; a rape complaint; to revise rape laws; and to make resources available to provide services for victims.

One of these kinds can be termed the national women's rights organizations—the National Organization for Women (NOW), the Women's Equity Action League (WEAL), the National Women's Political Caucus (NWPC), and others. These groups, which were formed solely to address women's rights questions, should be distinguished from other women's organizations, formed for other purposes—such as the General Federation of Women's Clubs, the Business and Professional Women, the League of Women Voters, and the Junior League.

The women's rights groups have adopted resolutions at their annual conventions making reform of rape laws and improved victim treatment organization objectives. They have set up task forces within their own structures to provide materials to any chapters that might decide to set up a local task force.

The National Organization for Women has been by far the most active of these groups. Its national task force, formed in early 1973, has, in addition to coordinating the local task forces, lobbied for federal laws to provide funding for rape-related projects, and monitored the grants made by the Law Enforcement Assistance Administration (LEAA). Over 200 NOW chapters with local projects on rape relief have pressed for change in many of the cities surveyed. NOW has the weight of a large national membership behind it and, in a growing number of localities, includes members who are influential in the community. It has become experienced in organizing women around specific issues and pressing for change from public and private institutions.

The second kind of organization that has been effective in achieving reform exists in several midwestern cities and is called Women's Crusade Against Crime. Its chief concern is to support, assist, and augment the criminal justice system in doing its job. For this reason, the Crusade would consider it counter-productive to denounce police, prosecutor, and hospital practices, because it might discourage women from reporting rapes. In Indianapolis, for example, representatives of appropriate agencies meet periodically (with the endorsement of the mayor) to make changes beneficial to rape victims. Margaret Post, a respected journalist and founding member of the Women's Crusade Against Crime, has been instrumental in the success of this group. Rather than publicizing through her writing the weaknesses of police, prosecutor, and hospital procedures, she has worked behind the scenes to improve these practices and then given positive publicity to the innovations.

The Women's Crusade Against Crime in St. Louis, which was patterned after the Indianapolis organization, has also been influential in improving systems that deal with rape victims, although the organization in both cities addresses itself to a broad range of criminal justice problems. Members of these groups are older and closer to political power than are rape crisis center volunteers, as a rule. In addition, since they support the efforts of law enforcement agencies by such things as providing volunteer services and campaigning for bond issues for police equipment, their requests for change on behalf of rape victims are met with cooperation.

Toledo United Against Rape is a coalition of people from all relevant agencies and organizations in the community, which also patterned itself after the Indianapolis group. Their work has been in public education, cooperating with and assisting institutions dealing with the victim, and investigating the need for law reform. Because key people in the coalition are well known and politically involved, the level of institutional cooperation and public acceptance is high.

3. *Education*. There is an element of community education in the carrying out of both the service and reform programs discussed above. However, educational programs such as those undertaken by rape crisis centers have been adopted by other organizations as well. The women's rights groups often carry out educational activities by writing and speaking on issues surrounding the subject of rape. NOW members in New York City, for example, have been seeking funding for an ambitious proposal to produce a film on rape.

In addition, the more traditional women's organizations, such as the National Council of Jewish Women, the Federation of Women's Clubs, and the Business and Professional Women (BPW), have recognized the problem of rape as one that should be brought to the attention of their memberships and have made it one of their program areas. This means that their national offices prepare and publish, in a newsletter or magazine, basic materials and ideas to assist chapters in planning programs. The target of these educational efforts is usually limited to the membership of the organization. Furthermore, it is not clear how many local groups use the materials. A questionnaire from the BPW to its chapters indicated, for example, that most did not follow through by holding programs on rape prevention, law reform, or the problems of victims in their meetings.

Although the audience reached through these organizations may be small, it is apt to be a very different one from the audience a rape crisis center or activist women's group contacts. Since all women are potentially rape victims, all should have basic information concerning prevention and reporting of rape, and the judicial process. The message must often be expressed in different, more conservative terms than that published, in the feminist or even the popular press.

At the other end of the socioeconomic scale are women who are usually not organized either to generate or to receive information or ideas about rape or anything else. They are poor, often minority women who can only be reached by radio or television or, perhaps, through a church group.

It should be restated that the information in this chapter is in some instances a year old. In the months since it was collected, new groups have formed and the involvement of organizations other than rape crisis centers has increased. No attempt to systematically update this material has been made since it has served its purpose as a foundation for the guidelines and recommendations contained in the next chapter.

CHAPTER XII. RECOMMENDATIONS FOR CITIZENS' ACTION GROUPS

The recommendations that follow are aimed at two distinct audiences–citizen groups and local government. In addition, the main text of the chapter is policy- and issue-oriented, while the appendix contains specific suggestions or factual material.

The sections for police, hospitals, and prosecutors are more process-oriented than this one. Since those agencies exist and perform similar functions in all communities, they are susceptible to standardized procedures. Citizen action groups, on the other hand, vary widely from place to place and among themselves in the same community. They may be established organizations or ones set up solely to deal with rape, traditional or radical in their approach, broadly based or representative of only a few citizens, influential or powerless. Many dissimilar ways in which they can act upon the problem of rape are suggested in this chapter.

Both program and structures are discussed. The appendix contains guidelines for fund raising, rape victim counseling, and program assessment, plus factual materials on rape law reform and the theory of rape victim counseling.

A. Program

There are at least four major program areas in which citizen organizations wishing to aid rape victims and to reduce the incidence of rape can work: (1) victim services, (2) public education, (3) catalyzing change within the criminal justice system reform, and (4) law reform. The discussion of each of these functions is an attempt to provide suggestions for groups beginning rape-related programs. It is aimed at issues rather than process with the expectation that most groups can develop the mechanics for carrying out a program so long as it is properly conceived.

However, one process with which community and citizen based activities are particularly unfamiliar and which we consider vital in an area as new and unexplored as rape reduction programs and rape victim support projects, is evaluation. Admittedly, groups having few resources with which to accomplish their program goals are in a poor position to acquire evaluation services. We suggest, however, that some form of self-assessment is necessary to every project, and we have supplied some basic guidelines in Appendix IV-B for use by groups until they can acquire more sophisticated help from, perhaps, a volunteer professional. Knowing how its performance measures up to its objectives is important to a group for morale as well as for fund raising purposes.

1. *Victim services*. This is perhaps the most ambitious of the program areas. A fully functional, comprehensive rape victim services project requires constant availability of trained personnel. Since few communities can afford to pay for such services, they must be provided largely by volunteers. Even with unpaid workers, rape crisis centers have found it difficult to meet the operating costs of an office, telephone, and other equipment, much less pay the one part-time or full-time coordinator who is invariably needed.

Any organization considering a service program ought to be certain that the job could not be done as well by an existing victim support, crisis intervention, social service, or mental health project if that project's personnel received training in the particular needs of rape victims. Time absorbed in arranging for a publicly funded agency or an established privately endowed institution to undertake this work may be well invested, considering that rape crisis centers report typically that it takes more than a year of operation before they become well known enough to be effective. This is often a discouraging period of high hopes and hard, uncompensated work resulting in little contact with rape victims.

If an organization concludes that it is appropriate to provide these services, it should estimate what its costs will be and how it can meet them. Contact with an already operating group in a comparable city can be helpful in projecting a budget and targeting fund raising activities. Many funding sources do not like to underwrite service projects unless there is some showing that with "seed money" for two or three years they can then become self-sustaining. Few donors want to be bound to be a grantee forever, and they do not like to think that when the grant period ends the project will lapse. Therefore, long-range planning must be undertaken from the start so that the funding source can reasonably believe that, for example, the services will be supported by government funds or through public solicitation once the community has become dependent upon them. Considering the trend in law enforcement agencies to establish support services for all victims, it is not unrealistic to expect that some services will eventually be available through such programs. (See Appendix IV-E for detailed guidelines for fund raising.)

a. *"Hotline"–information for the victim immediately after the rape*. Women who have been sexually assaulted usually have no idea what to expect if they go to the police or to a hospital. Fear of the unknown or of what they believe will happen to them prevents most victims from seeking help or justice from the systems that should serve this purpose. There are two approaches to this problem. The first is public education to help women and children know what they can do if attacked, so they do not have to make this decision in the aftermath of the experience. (See Public Education.)

The second is to provide an information center or "hotline" that victims can call anonymously to receive information and advice. This can be located within a rape crisis center, a hospital, a prosecutor's office, or even a police department, although identification with law enforcement agencies will discourage may would-be callers. It can be a multipurpose crisis line, an ombudsperson's office, or any other human services agency. But it should be a well-known number, such as 911, or one that is easily ascertainable from the telephone directory. It should also be answered on a 24-hour basis–preferably by a knowledgable and understanding woman.

An organization that undertakes to operate a hotline has two major hurdles to overcome–funding and outreach. To provide services around the clock, seven days a week, requires four times the personpower needed to staff a business office. Obviously, if all workers were paid this would be a very expensive proposition. Most groups, therefore, draw heavily on volunteers but have difficulty locating help for certain shifts, especially at night. This is particularly true of counseling centers that want to have someone physically present in the office to be immediately available to a person in crisis.

Even in large cities and high crime areas, however, it has been possible to deliver adequate services during nighttime hours, using several less costly systems. First, a commercial all-night answering service, available in most cities, can be hired to do one of several things when an emergency call is received from a rape victim: (1) give the caller the number of a volunteer who is standing by at home, (2) ask the caller for a number where a volunteer can call her right back–and pass the message to the person on duty, (3) "patch-in" the victim's call to a call to the volunteer. The last of these is the best, although most expensive, alternative because it avoids having the victim make a second call or wait for a return call, either of which can be discouraging to a person who is upset.

An even more sophisticated and costly system, which is less confining for the volunteer, is a signalling device such as doctors wear to alert them to emergencies. A telephone company may also offer a service whereby a staffer leaving her or his office can phone the company and advise it of a number to which all calls should be switched until further notice. A caller will be unaware that the answered phone is not in the office.

In addition to the cost of office space and telephone services, a group operating a hotline must consider the human resources being expended on the program. Besides the time volunteers spend on duty, many hours can be absorbed in training them and in the periodic task of scheduling their services. Although a group may be disinclined to apply cost-benefit analysis to a service they consider essential at any price, it makes sense to see whether the same objectives can be obtained in less exhausting ways.

In communities with an existing crisis line (for suicides, drugs, runaways, family crises, etc.), combining the rape hotline with those services should be explored. This is especially true where the incidence of rape is low and the existing service, whether publicly or privately financed, is well known and well liked. Any cooperation of this kind would obviously require a meeting of the organizational minds on how to handle rape crisis calls and would doubtless also demand special training for the staff on ways in which rape-related crises differ from other crises.

The problem of cost effectiveness is closely related to the question of the outreach capability of the organization. A program that is unknown or unacceptable to the community cannot be effective. Publicity is a good antidote for obscurity, and rape victim services can usually gain the attention of the local press, radio, and television. Funded projects can run high impact ads in appropriate newspapers, and programs sponsored by local government can sometimes get free advertising on a municipal bus, for example. Public service announcements may be made available to any group.

In short, becoming known is not as difficult as becoming acceptable or desirable. A hotline really has to sell its services by making clear what it offers, why it is needed, and why it is not available elsewhere. If persons of all ages, races, economic circumstances, and political persuasions are welcome, that ought to be articulated. On the other hand, if the program is aimed primarily at women who seek an "alternative" to traditional institutions, that should be clearly stated. If the sponsoring organization has been active politically or has a strong feminist image, it can expect that some women will reject its services. Its relationship to the criminal justice system should be made clear, and if anonymity is guaranteed, that, too, should be announced.

Even when a good foundation is laid in the community, it may take up to a year for a rape crisis line to become established. Experience has shown that the start-up period can be discouragingly long. Although rarely designed to be so, hotlines are often used by people who want to know about the service rather than use it—journalists and other groups who want to start a hotline, for example.

The services offered victims, their families, and their friends through a hotline are discussed below.

b. *Crisis counseling for victims.* Little is known about the special needs of rape victims. An ongoing longitudinal study of victims at Philadelphia General Hospital should yield valuable data on this subject. Meanwhile, most of what is known is drawn from the experience of groups that have in the past several years offered information and help to sexually assaulted women but have not systematically studied the beneficiaries of their services. A notable exception is a report[1] by Ann Burgess and Lynda

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[1] Ann Wolbert Burgess and Lynda Holmstrom, *Rape: Victims of Crisis* (Bowie, Maryland: Robert J. Brady Co., 1974).

Holmstrom on their work at Boston City Hospital, which is recommended as a guide to rape crisis counseling. (See Appendix IV-C for a discussion of the social psychological aspects of rape.)

A few principles seem to be agreed upon. Most victims who call a hotline immediately after an attack need information in order to decide what they should do about reporting the crime, meeting their medical needs, telling their family and friends, and sorting out their own feelings. Many want help making decisions and should be assisted in drawing their own conclusions (not the counselor's). This is so not only because the victim must live with her own decision, but also because by making choices for herself she is exerting control over her own life; her sense of having such control may have been greatly diminished by the rape. Some women who have been assaulted simply wish to ventilate their anger, fear, shame, or other feelings. Others expect and need a sympathetic reaction and emotional support. Victims experiencing great distress may need professional help. If a woman calls a counseling center weeks or months after an attack because of lingering effects of a rape or reemerging problems related to the assault, she might benefit by peer counseling, self-help programs, or "rap groups" with other victims, although groups that have experimented with these techniques report mixed or negative results.

It is generally agreed that most victims do not need to be evaluated by a psychiatrist or other mental health professional after a rape and that to suggest psychological care to a woman could be detrimental unless such care is clearly called for by her behavior. This may be, however, the only point of general agreement on roles of professionals and nonprofessionals in the counseling of rape victims. Many feminists reject basic psychiatric theory and distrust professionals whose training has been based on those ideas. Some women (especially racial minorities, the poor, and the young) distrust all professionals because of their generally authoritarian demeanor and find it difficult to locate individual mental health professionals with whom they feel comfortable working. They believe in the therapeutic effect of women helping women and women helping themselves.

Acknowledging that there are lay persons who have much more experience with rape victims than most professionals and who have the personal characteristics to be better counselors, we nevertheless believe that the involvement of persons trained academically or clinically in crisis intervention, female sexuality, interpersonal relationships, and human behavior can be useful to a rape victim counseling program. They can serve as trainers, as consultants when problems arise, or as persons to whom a difficult case can be referred with confidence.

Most rape victim counseling has taken place through rape crisis centers, but other kinds of public and private counseling organizations are beginning to undertake this responsibility. Some hospitals are also adopting protocols that call for victim contact with a social worker, nurse, doctor, psychiatrist, or community volunteer just as soon as possible after her arrival at the hospital. Male chaplains are taking on this job in some hospitals where they are being trained to minister to patients. There have been, as yet, no studies that show whether these or other male counselors are as acceptable to rape victims as are females. A few police departments and prosecutor's offices also employ counselors or contact an outside group when a victim reports to them and wants help.

There is much to be said in favor of a counseling capability located outside the criminal justice agencies and the hospitals. Most importantly, women who do not wish to report a rape (and they are the vast majority of victims) are more apt to approach an independent organization. Second, a victim who does go to the authorities and needs a counselor is likely to prefer to deal with one person throughout the processing of her case and afterward. A counselor who can meet her immediately and accompany her to the hospital, the police station, the prosecutor's office, and the court will provide more continuity than, for example, an emergency room nurse. Unfortunately, however, personnel from community groups may not be welcomed by police, prosecutors, or hospital staffs unless a foundation for this cooperation has been laid and is maintained through mutual confidence and respect. (See discussion on advocacy.)

Counselors who are put in touch with rape victims through a hotline may never meet the woman they counsel or even know her name. Whether the contact is brief or prolonged, by telephone or in person, a number of principles that apply to all crisis counseling and some that concern only rape victims must be learned by the counselor. Training is an essential component of any counseling program. Materials used for training in two rape victim counseling centers are attached as Appendix IV-D. In addition to their usefulness in the training context, they provide specific guidelines for groups considering whether to set up such a service.

c. *Assistance with housing, transportation, child care, etc*. Women who have been assaulted are frequently afraid to be alone in their homes or to travel by themselves. It is not unusual for rapists to threaten to return and to retaliate if a woman goes to the police. Victims may need temporary lodging, someone to accompany them there, child care, medical prescriptions filled, assistance in notifying family or friends, and a host of other social services. Women's centers and rape crisis centers have assisted rape victims on a temporary basis, but those that have sought to provide shelter for women who are in danger or abused have found their facilities overtaxed.

Several cities have recently established innovative programs to help victims of all crimes with social services. Most communities take care of these needs through private philanthropy, churches, and social service agencies. A list of contacts in these institutions who have agreed to provide services should be available to all counselors. Victims should be helped to meet their own needs rather than encouraged to rely on others. Self-sufficiency can help restore a woman's positive self-image if it has been damaged by the sexual assault.

d. *Advocacy*. The name "rape victim advocate" has been used by citizen organizations for a person who accompanies a victim through the criminal justice system and represents her interest there. The very term implies adversity of interest between the system and the victim and also suggests a system sufficiently hostile that a trained advocate is needed to prevent abuse of the complaining witness.

The fact is, however, that it is ordinarily impossible for the advocate to function at all without the consent of the agencies and institutions through which he or she must guide the victim. As a practical matter, advocates cannot confront police officers, prosecutors or hospital personnel without jeopardizing the cooperation that permits them to be present at critical stages of the case and may give them initial access to the victim.

They can, of course, counsel with a woman on her possible responses to law enforcement personnel. To this extent these people are really counselors rather than advocates and should be so known since that title is apt to evoke less antagonism from the criminal justice system. We have occasionally referred to counselor/advocates because even in groups where the functions of a counselor and an advocate are distinguishable, they are actually carried out by the same person.

Victim advocacy is important, however, and should be a major effort of an organization whose purpose is to aid rape victims. The model we suggest for this activity is described in the section on bringing about change in the criminal justice system, because we believe that abuse of victims is a problem that cannot be solved in a case by case basis.

We do believe, however, that victim counselors gain important insights into the ways in which the justice system aggravates the harm already done to the woman by the rapist. A good counselor/advocate would understand the law enforcement and judicial process well enough to draw important conclusions regarding changes that could be made in the victim's interest. Finding a means through which the product of those observations and analyses can be used constructively is the subject of the section on catalyzing change.

e. *Anonymous reporting (third party reporting).* This term refers to the practice of having rape victims report the crime to a person or group other than a law enforcement agency, with the understanding that detailed information about the crime, but not the name of the victim, will be passed on to the police. Although no suspect could be apprehended or prosecuted on the basis of such a report, the police might use the information in the investigation of another case where, for example, someone using the same modus operandi raped another woman, but she could not give a good description of him.

Although rape crisis centers are making such reports to the police in several cities, other law enforcement agencies have refused to accept them. Some police departments simply do not have information systems and investigation methods sufficiently sophisticated to make the report useful. In other cases where departments do not wish to cooperate with crisis centers in this way, they may be concerned that women are discouraged from reporting directly to them by the offer to relay an anonymous report.

Whether or not a hotline or counseling center encourages victims to go to the police is usually a political question governed by the group's feelings about criminal justice in general and the agencies in its own community that carry it out. A group that discourages reporting is seldom interested in an anonymous reporting system, since it usually is not inclined to assist the police in any way. Groups that either encourage reporting or try not to interfere in the woman's decision do not recommend anonymous reporting until the victim has stated a clear intent not to report. At this point, a third party report preserves two possibilities. First, the woman who at first refuses to go to the police may change her mind later; and the fact that she reported immediately after the crime, although indirectly, strengthens her case. Second, if, when the report is made by a third party, the police feel the woman's testimony would help convict someone who is already a suspect, it may be possible to convince her to cooperate.

Even when third party reporting is not valuable in apprehending rapists, information gathered in this way could be a useful indicator of how many rapes are not reported to the police, what kinds of victims do not report, whether rapes in certain neighborhoods are less apt to be reported than others, and why a victim would choose not to report.

2. *Public education.* Four major topics are appropriate for inclusion in public education programs about rape. Here they are referred to as: (1) Prevention, (2) Resistance, (3) Reporting the Crime and Seeking Help, and (4) Myths and Misunderstandings. These headings outline a chronology of concerns that the public has about rape—how to avoid attack, whether to resist if assaulted, what to do after rape, and attitudes toward the crime.

Although information is available on each of these subjects, it is far from definitive and is often considered controversial. It is, therefore, recommended that educational programs should recognize the valid debate on all sides of important issues so that audiences can draw their own conclusions and individuals can make their own decisions about which actions to take. In other words, the purpose of the programs should be to inform rather than to advise.

Each of the four topics can be the subject of a separate program, or several can be used in combination. Here some of the kinds of information and issues that should be dealt with are mentioned, and sources from which the content of a program might be drawn are suggested. In addition, this section addresses some practical problems with respect to funding, target audiences, and media.

a. *Prevention*. The subject of how women can make themselves less vulnerable to attack can be divided into discussions of safety indoors (the home and office) and outdoors. Advice about security in a house or apartment must deal with, for example, locks on doors and windows, peepholes in doors, lighting around entrances, not listing first name in a telephone directory, and not opening the door to unfamiliar persons. Apartments present the additional hazards of elevators, corridors, laundry rooms, trash rooms, and parking lots. Rules for safety in apartments also apply to offices, which have the additional danger that public lavatories can harbor a rapist.

Although most rapes occur inside, some especially dangerous situations occur outside. Hitchhiking is probably the most risky, whether the woman is hitching or whether she picks up a male rider. Automobile breakdowns occasion problems for lone women, but so do more ordinary occurrences like taking shortcuts through alleys and getting into an unlocked car without checking the back seat for an intruder.

Checklists of safety measures can be gotten from or compiled with the help of the police department in most places. An inexpensive book, *Rape* by Carol V. Horos, discusses techniques for avoiding attack and is available commercially. (See Appendix IV-F for a list of resource materials.)

Instruction in methods of keeping safe from rape introduces the pitfall of suggesting to women that if they are raped as a result of their "carelessness" they are at fault. Many women's life styles, by choice or necessity, include traveling alone at night, occupying an insecure dwelling, or other activities that make them vulnerable to assault. Their right to live this way should be respected and not be interpreted as an invitation to rapists. Material to this effect ought to be included in the course or literature used.

b. *Resistance*. When and how a woman should resist a rapist are under hot debate. Because so little is known about why men rape, how they choose their victims, and how a woman can deter an attack, the development of a responsible program for teaching women to resist rapists should not be undertaken lightly. The few published studies of convicted rapists indicate that there are three or four different categories of offenders whose motives, methods, and reactions to resistance differ.[2] Since rapists do not wear identifying labels, a woman cannot know which type she is confronting.

In addition to this problem, it is also not known whether, even if they could be taught the best tactics to use against an assailant, every woman would be capable of carrying them out. In Denver, research on a small sample of rape victims and women who successfully resisted attack has indicated significant differences in personality traits between the two groups. The women who were successful in defending themselves, when tested, demonstrated greater dominance, sociability, and self-presence than the victim group, which exhibited more fear, depression, nervousness, and anxiety.[3]

Although these studies are inconclusive, they indicate the difficulty of devising reliable and generally applicable self-defense schemes. There are two schools of thought on the matter. The foundations of both are largely intuitive, but each is bolstered by some preliminary empirical data. The research and logic underlying the two arguments should be carefully considered before a program is undertaken.

One line of reasoning is that since there is always a possibility that a rapist will murder or mutilate his victim, a woman should never do anything to threaten or antagonize him until she is certain either that he means to kill her in any event, or that she can incapacitate him and escape. Frederic Storaska, a lecturer to college audiences and author of the book, *How to Say*,

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[2] See, for example, Cohen, Garofalo, Boucher and Seghorn, "The Psychology of Rapists," *3 Seminars in Psychiatry* 307 (1971).

[3] Carolyn J. Hursch and James Selkin, *Annual Report, Rape Prevention Research Project*, October 31, 1974, Violence Research Unit, Division of Psychiatric Services, Department of Health and Hospitals, Denver, Colorado.

No to a Rapist and Survive, is the chief proponent of this strategy.

Feminists who disagree with Storaska's message argue that rape can be avoided by women who immediately verbally or physically counter an attack. They cite several studies indicating that a significant number of rape attempts are thwarted by women who assert themselves at the first sign of danger without regard to what the man's reaction will be.[4]

A dogmatic approach from either side of this issue is inappropriate, indeed dangerous, in light of the lack of knowledge of what is effective and the fact that every combination of rapist and would-be victim presents different possibilities for interaction. Whether screaming, punching, kicking, and running will intimidate a particular rapist or infuriate him simply cannot be known. Moreover, an educated guess can hardly be made on the basis of available information. This is a disappointing fact for both speakers and audiences who would prefer that unequivocal advice could be given. Because the fear of rape is so strong in most women, their desire for a clear-cut plan of action in case they should be attacked is intense.

Although it is impossible to devise a rape resistance strategy that will be successful for all women against any rapist, an audience can be told what a woman's options are and the pros and cons of using them. They are basically three–resistance, passive resistance, and submission.

An active reaction to an attack, whether a fearful scream or a courageous jab, will be threatening to a rapist. He may respond by running away or by beating, stabbing, and choking his victim. A woman properly trained in self-defense will be realistic about her ability to protect herself. Courses in the martial arts are available commercially or through clubs in most places. Because they are rigorous and time-consuming, they are not pursued by large numbers of people, men or women. The kind of instruction feasible for most women is a combination of the knowledge of a few blows that are guaranteed to incapacitate, adequate physical fitness to permit her to run fast, and practice in overcoming inhibitions about screaming.

Passive resistance is essentially an attempt to convince the attacker that he does not want to have forced sexual relations after all. This can be accomplished by appealing to his morals or his mercy, by doing something disgusting to reduce his sexual arousal, by promising to voluntarily have sex with him later somewhere else, by appearing to faint, or by any means that does not threaten him.

An important element of any program on defense against rape should be emphasis of the right of the woman to submit. Although some people successfully resist robbery, others are killed in the attempt; so no one is counseled to fight a robber. Although there are different values at stake, the choice should still be the victim's. Even a person who wants to resist and is trained to fight may be unable to do so when confronted with a situation which she or he perceives as dangerous. The fact that a rape victim thought she could protect herself and failed may heighten the feelings of inadequacy and guilt that can result from rape.

A possible long-term remedy, which should be suggested to citizen groups, is the initiation of improvements in physical training for girls, adolescents, and teens in schools and through community recreation facilities. Despite the lack of research into this area, it may be hypothesized and hoped that a generation of women who are stronger, more self-assured, and assertive will be less vulnerable, not only to rape but to other kinds of abuse. In fact, such training might also help alter attitudes toward women that may foster the feeling of some rapists that they can get away with such abuse of women.

c. *Reporting the crime and seeking help*. Just as women want to know how to react if attacked, they are interested in learning what they ought to do in the aftermath of a rape or attempted rape. Ideally, every victim of a crime would immediately notify the police so that the perpetrator could be apprehended and thereby prevented from harming others. Many people do not report crimes, however, and rape is among the least reported.

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[4] Stanley L. Brodsky, *Prevention of Rape: Deterrence by the Potential Victim*, unpublished, University of Oklahoma, 1975 and T. Giancinti and C. Tjaden, *The Crime of Rape in Denver*, 1973 (a report of the Denver Anti-Crime Council, mimeo).

There are many reasons why a woman may not wish to prosecute a man who has raped her. They include: her feelings toward herself (shame, embarrassment, guilty), her feelings toward the rapist (fear, hatred, pity), her feelings toward others (not wanting to upset parents, husbands, lovers, children), and her attitude toward the criminal justice system. For some women reporting is an impossibility, for others an inevitability, but for most it remains an open question; the answer to which may be influenced by a public education program.

A preconceived plan of action for emergency situations is always useful because it is so difficult to make decisions in the wake of a frightening or upsetting episode. Because the law places a premium on the promptness of a rape complaint, a decision to prosecute must be made quickly. Furthermore, valuable evidence that must be collected during a pelvic examination of the victim will be lost if she bathes, douches, or delays the examination.

The threshold question for every woman, then, is whether to notify the police. An educational program should address both sides of the issue—her civic duty to do so and the problems she invites if she does. The line between information and advice can become very thin unless the speaker has some facts as well as opinions to offer.

Information about the rates of reporting, clearance, and conviction in rape cases in the appropriate jurisdiction can give a woman an idea of the likelihood that her complaint will, in fact, "get a rapist off the street." If those figures are discouraging, they might be balanced, for example, by a dramatic case history of a woman whose cooperation led to the conviction of a particularly dangerous rapist.

If police, prosecutors, and hospital personnel have taken steps to humanize the processing of a rape complaint, this should be brought out. A report from a recent victim on her experience in the criminal justice system would be useful. The procedures in which the rape victim must be involved should be explained; the number and nature of the appearances she must make and the approximate time involved, whether she can expect police protection if the accused is free on bail, and the personal information that is apt to be sought in police interviews and on cross-examination should be described.

A number of arguments for cooperation with the government should be made. These include not only the altruistic view that a victim's cooperation may save another woman or child from attack but also some self-serving reasons for a woman who has been raped to prosecute. Not the least of these is that it may be therapeutic to use the law enforcement system against the offender as a conduit for the anger that a person who is injured naturally feels.

As has been suggested, whether or not to report a rape is a personal question that must be answered by every woman for herself on the basis of as much information as possible. It is also a political question for organizations sponsoring education programs. Some have no faith in the ability of the justice system to solve the problem of violence in our society and so see no reason for rape victims to become involved with it. This point of view merits public discussion, but it should not be an unexpressed reason to discourage citizens on other grounds from using the only socially sanctioned means of redress available to them.

If a woman decides that she would go to the police if raped, she will want to know how she should proceed. Often she will need only a phone number to call and a reminder not to destroy evidence. She should also know that once inside the system she should be taken to a hospital where she can receive the medical care she may need to prevent pregnancy and venereal disease. In a progressive city or town she would also be referred for any social or mental health services she might need.

If a woman decides that she would not go to the authorities, she will want to know what alternative means are available to meet needs that may be occasioned by the crime. If a rape crisis center or other community group or agency provides services or information on a 24-hour basis, its telephone number may be all that is needed. Otherwise, women will want a list of medical facilities that will accept rape victims for medical treatment and will administer prophylactic care for V.D. and pregnancy. Counseling services and mental health clinics experienced with rape victims should be listed, as should such other social services as temporary shelters and child care services.

d. *Myths and misunderstandings*. Much of the traditional wisdom about rape is now being rejected. There is a growing body of evidence to refute beliefs that, for example, men rape women who act or dress seductively, women secretly want to be raped, or rapists are psychopaths. A new, but still incomplete, understanding of the crime has been reached and should be disseminated. Several recent books (see Resource List) offer information and ideas useful for public information programs, discussion, and debate.

Perhaps the most prevalent myth regarding rape is that most men who rape are seeking sexual gratification. Studies of and interviews with prison populations[5] indicate that rapists often have consensual sexual relationships available but choose to rape because they enjoy overpowering their victim. In terms of the perpetrator's motives, rape bears a closer resemblance to violent crimes such as assault and robbery than it does to sexual intercourse with a consenting woman.[6] This is a fact that all potential victims and their families and all prospective jurors and judges ought to know.

Because of the general acceptance of certain myths and the common ignorance regarding human sexuality, situations develop between men and women that are viewed as rape by the woman but not by the man and usually not by the criminal justice system. These are what Germaine Greer calls the "petite rapes," which often grow out of social situations.[7] Because they are the natural consequence of the socialization of boys to be powerful and aggressive and girls to be passive and submissive, these rapes can be viewed as "misunderstandings." For example, boys are taught that girls say "no" when they mean "yes," and girls believe that a boy will stop whenever a girl asks him to.

At the root of these situations is a lack of education of young people regarding male and female sexuality. Sex education that includes not only the biological but the social and political aspects of sex is missing from the curriculum of most high schools and junior high schools, the educational level at which it is most needed.

Interesting new theories regarding class and cultural differences in patterns of rape, and motivation of the rapist, and the coping mechanisms of the victim are emerging and should be considered when a program is planned for a specific audience. For example, to poor women rape may be just another form of the exploitation they learn to absorb. To a woman who has led a protected life in a chivalrous society it may be the ultimate disappointment. Approaches to these groups should be different in form and content.

e. *Practical considerations*. As with other programs, public education efforts ought to be planned. Beyond the considerations of content discussed above are several problems. The message needs to be designed for a specific audience to realize previously agreed-upon objectives;

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[5] *The Washington Post*, June 15, 1975, p. El and June 16, 1975, p. Bl.

[6] Gene G. Abel, Denis Madden, and Russel R. Christopher, "The Components of Rapists' Sexual Arousal," Panel at the American Psychiatric Association Annual Meeting, May 1975.

[7] Germaine Greer, "Seduction is a Four-Letter Word," *Playboy*, September 1974.

access to that audience has to be achieved; and the program needs to be carried out with resources available.

Several simple models are in use. Some organizations, such as the General Federation of Women's Clubs, develop programs for their own members during regularly scheduled meetings. Other organizations, such as rape crisis centers, attempt to educate groups besides their own membership. Often a volunteer from the service group makes an informal presentation upon an organization's request for a program on some aspect of the rape problem. The host organization frequently pays an honorarium to the speaker or to the rape crisis center, which may find that these donations are a principal contribution toward its operating expenses.

More aggressive and sophisticated models for public education are needed. Information should be directed toward those groups apparently most involved in the rape problem—the young and minority populations. Schools are an obvious place to begin, but access is often a problem because subject matter related to sex is considered highly sensitive.

One program that has penetrated these institutional barriers is being carried out in Orange County, California, by a nurse and a diminutive female karate expert, both of whom are of an age to have children in the high school classes they address. With the sponsorship of the local Junior League, which pays them a modest fee for every appearance, they usually address girls' physical education or health classes. Their presentation includes a slide show that, among other things, effectively contrasts romanticized rape (as in the classical paintings of the Rape of the Sabine Women) and realistic rape (depicted by police photographs of a battered victim, used with her permission, of course). Although it is high impact material, it falls short of sensationalism.

Specific objectives must be decided upon at the outset of any public education program in order to formulate the message properly and to choose the most effective medium. For example, a full page ad in a major newspaper may be the best way of letting certain women know about the services of a rape crisis center, but it would not be a preferred method for helping teenage boys understand the dynamics of peer pressure that can lead to "gang rapes."

If it can be assumed that persons between the ages of 15 and 25 are the most important group to educate about rape, decisions must be made about what they need to know, how to reach them (television, school programs, or courses), and how to interest them. A group that has thought through these questions carefully and can articulate answers has a reasonable chance of finding financial backing if needed.

Some writers and lecturers have put together rape-related materials and programs that have reached vast audiences and have been quite profitable. A program or literature that is self-sustaining, or even lucrative, is obviously more desirable than a costly one, unless, of course, the message is distorted by the medium.

A similar caveat should be registered with respect to the mixed blessing of the still enlarging interest of the mass media in the subject of rape. For example, dramatizations of cases of rape on television are credited by the police with discouraging the reporting of the crime but, on the other hand, they probably bolstered the efforts of citizen groups to bring about changes within the criminal justice system.

The same surge of interest has led to an increased demand upon community leaders and activists to participate in television, radio, and other public discussions of rape. This often provides spokespersons access to an enormous number of readers, listeners, or viewers; but it also presents the problem of lack of control over the content of the overall message. With few exceptions, these media strive not only to educate, but to interest and even to entertain. A group that agrees to participate in such a program or interview ought to know its objectives in doing so and be sure that they can be accomplished within the format, time, and other conditions of the program.

3. *Catalyzing changes in the criminal justice system.* The ways in which rape victims are regarded and the consequent way they are treated in many police departments, prosecutor's offices, hospitals, and courtrooms is now notorious. In some jurisdictions, law enforcement and judicial response to the crime of rape and the medical treatment of the victim have already been improved. Where this has not yet occurred, it can be brought about in the following ways listed in a descending order of preference:

a. *Spontaneously by administrators.* When a police chief, sheriff, district attorney, or hospital administrator decides to make changes, they usually come about. To the extent that the reforms represent a personal commitment of the person empowered to order them, they will be carried out. The same person acting in response to external pressure is apt to do a less effective job.

b. *As a result of staff pressure.* When a detective, assistant prosecutor, or emergency room nurse decides a change is needed and knows how to rally support for a reform proposal, prospects for improvement are also high. Concerned citizens have often been instrumental in convincing these insiders to act, just as they have occasionally been behind an administrator's apparently "spontaneous" response to the problem.

c. *A plea for cooperation from another agency.* One agency committed to changing its procedures can stimulate related agencies to action if it acts prudently. Its ability to do this depends on prior relationships among the groups and whether the acting agency is sincerely trying to ease the tribulations of the rape victim or whether it simply wants to improve its own image.

d. *Pressure from outside groups.* This is the least effective way to achieve change, but it is often the only recourse, at least initially. Theoretically any group can apply pressure, but as a practical matter an organization that is not broadly based and credible in the community will have to compensate with ingenuity and energy to be successful. It is often useful to form a coalition of community organizations so that the effort to force change cannot be undercut by discrediting one group. The support of influential people can help immeasurably. The following steps are suggested:

(1) *Investigation into local practices and the law.* The sooner this is done the better. This investigation ought to be done by a task force that is both official and independent of the institutions to be scrutinized. Governors, mayors, county managers, city councils, commissions on the status of women, and human rights commissions, are all possible candidates to sponsor the investigatory body. The investigators must understand both the feelings of the sexually assaulted woman and the way the criminal justice system functions. There are such people in every community.

(2) *Community hearings.* These should also be official and as inclusive as possible of all elements of the community. Hearings flush out information—anecdotes as well as data. Citizens are able to air their opinions. Defense attorneys tell how they won cases because of poor preparation on the part of the government. Former prosecutors testify as to the incompetence of the police. Victims tell of callous doctors and nurses. Prominent people paint the unhappy truth about how rape cases are handled in their community. Press coverage is usually good and accomplishes considerable consciousness raising among the general public. The unfortunate side effect of possibly discouraging the reporting of sexual assaults might be overcome if there is an immediate and well-announced move to reform.

(3) *Report and recommendations.* These should emanate from both the investigation and the hearings. The recommendations will reflect the prejudices of the individuals who make them, so the composition of the task force and the witnesses at the hearings are important to the result. Time and momentum are often lost waiting for a report to appear, so pressure must

be applied to get it completed and released. If necessary, offer to type, transcribe, or collate to quicken the pace. If it is difficult to get a commitment from an official body to investigate, hold hearings, and issue recommendations within a year, a credible private organization such as a bar association or a medical society might be persuaded to do this work.

(4) *Support for recommended reforms*. Once satisfactory recommendations have been published, they must still be put into effect. Appropriation of money or a change in the law may be required. Citizen support will be necessary and usually does not arise spontaneously—someone must organize it. Again, influential people and groups should be approached and rallied. If the recommendations fall short of the hopes, a new campaign must begin. Groups that are tax exempt under Section 501(c)(3) of the tax code must be careful about their involvement in pressing for legislation, but the major women's rights organizations are not precluded from lobbying.

(5) *Monitoring the implementation of reform*. Of the objectives mentioned, this is the most important and perhaps the most difficult to attain for two reasons: (1) unlike the other activities, it does not culminate in a final product or event; and (2) it can only be done effectively by an outside person with access to the inside. Every effort should, therefore, be made to build an evaluation component into the reform recommendations.

Failing this, some group committed to the issue must make sure that procedures agreed upon are actually being used. Where a counselor/advocate from a rape crisis center or other group accompanies a victim through the process, she or he has the ability to observe how the system works. A third way of accomplishing the monitoring objective is to form a standing committee of representatives of all involved agencies and women's groups to meet periodically to discuss breakdowns in the process. This is a good method of dealing with problems of coordination among the agencies but is unlikely to uncover internal problems.

4. *Rape law reform*. About half the states have already passed or proposed changes in their rape laws. The major issues and examples of how some states have dealt with them through law reform are contained in Appendix IV-A. This section will focus on the role of a citizen group in having such changes enacted.

One way to proceed with this objective is to call on the governor to appoint a task force to study the rape law and recommend changes. But unless the governor is sympathetic to your goals, she or he could ignore the request or appoint a task force of unsympathetic persons. Alternatively, another official, or quasi-official body such as a commission on the status of women, or a bar association, could be asked to do the study; but the problem of assuring a task force of change-oriented persons remains the same.

The benefits of an officially sponsored approach are that it places the burden of the work on people who usually have the resources to get it done and who will be influential enough to effectively support their own conclusions. However, if they cannot be counted upon to make recommendations that will achieve your group's goals, you should consider another route to the legislature.

Any citizen organization can work for review and reform of its state's rape law, but some knowledge of both the judicial and legislative systems is necessary. For this reason, lawyers and law students can be very helpful. Law professors, bar associations, organizations of women lawyers, women's litigating groups, and students who can undertake such projects for credit should be approached as resource persons.

Lawyers can teach others how the judicial system is structured and how a criminal case moves through it. Important concepts that should be stressed are the nature of the adversary system of justice, the burden of proof on the state in criminal trials and how it differs from civil cases, and the goal of "normalizing" the crime of rape or bringing it into line with other felonies.

Much can be learned by court watching—sitting in on rape trials to observe procedure and the demeanor of officers of the court. There is also literature available to assist in the education process. A "Lay Advocate Training Manual" published by Chicago Legal Action for Women may be obtained for $3.00 by writing to CLAW, 5609 N. Broadway, Chicago, Illinois 60660. The Handbook on Prosecutor Response to Rape, which is part of this report, could also be helpful.

Once a knowledgeable committee is assembled, the existing state law and model laws should be compared. Appendix IV-A can be used as a guide to state statutes that might be used as models. Persons active in obtaining passage of laws to be emulated should be consulted so that the problems they encountered can be considered before drafting begins. (See Appendix IV-A for names of individuals.) Writing legislation is a highly technical skill, and poor drafting can change or dilute the impact of the law.

In seeking sponsors for the bill, members of the appropriate legislative committees should be approached first. At this stage an understanding of the legislative process is important. Legislators in every state should be able to supply constituents with information on how a bill becomes law. The local chapter of the League of Women Voters is another source, and it may also have materials on lobbying, which is the next step in the process of changing the laws. "The Majority Wins" is an excellent booklet on building a program for legislative change, written by a feminist and available from Box 954, Lansing, Michigan 48901, for $2.18 postage paid.

Since rapists have no lobby, the major opposition to reform measures can be expected from public defenders, the defense bar in general, and groups, such as the American Civil Liberties Union, that are vigilant with respect to the rights of criminal defendents. The support of a few lawyers from these groups could be influential.

There are persons who are concerned about the problem of rape but who genuinely feel that changing the law will have little effect upon the crime or its victims. Generally, they believe that the conviction rate for rape is low primarily because of the attitudes of judges and juries, rather than because of the law. We believe that law reform is important—if only because bad law reinforces bad attitudes. Although there are no data as yet to prove it, we expect that conviction rates will rise in jurisdictions with improved laws.

We, therefore, encourage all organizations not tax exempt under Section 501(c)(3) of the Internal Revenue Code, which prohibits lobbying, to take the initiative in or, at least, lend support to amending state rape laws.

B. Community Cooperation

The recommendations in this section are aimed at community leaders, in official or unofficial capacities, who are in a position to influence the way in which a city, county, or state responds to the problem of rape. Most of the activity we observed in the course of our project was unplanned, uncoordinated, and, to a large extent, unsuccessful when measured against the hopes of the people involved in the effort.

Any organized attempt to improve the ways in which the community agencies and citizen groups deal with the crime of rape and its victims ought to include the following four tasks: (1) investigation, evaluation, and self-assessment; (2) recommendations and goal-setting; (3) coordination; and (4) monitoring. Each of these will be described below, and four models will be suggested for structures within which they could take place.

1. *Functions.*

a. *Investigation, evaluation, and self-assessment.* The importance of understanding how the system works was stressed in the previous discussion of how citizen groups can catalyze reform. Institutional barriers to change must be appreciated before new solutions to problems can be undertaken. What would seem to an uninformed outsider like a simple step toward improvement, might actually require a major reorganization or reallocation of resources.

No agency enjoys being investigated or evaluated, and the job can be made impossible unless the cooperation of the organization being studied is obtained. It must be led to understand how this study can aid it with its own planning processes and, possibly, help to justify its need for budget increases. The use to which the information gathered will be put should be explained. While it must be expected that certain data and conclusions will be published to support recommendations, it should be emphasized that the objective is not to embarrass the subject of the study but to gather the information needed to make responsible recommendations.

b. *Recommendations and goal-setting*. These should be more than the suggestions of an outside group or individual to the agencies or organizations who would implement them. Ideally, recommendations should be developed in conjunction with the police department, hospital, prosecutor's office, or other agency affected by them, inasmuch as they will have to be implemented there.

Some of these goals should be the kind that can be carried out within a reasonable period of time; for example, the development of a protocol, the establishment of periodic training programs, or the production of an information and referral booklet. Others may be longer range proposals (like setting up a 24-hour hotline and counseling service or a special rape prosecution team), because they require more planning and, usually, additional resources.

Some communities may be ready to integrate their response to rape with a larger program of support for all victims of violent crimes, or with a project to aid women who are physically abused by their husbands. Where there are well-developed plans or initial stages of such programs in the community, it may make sense to see how the needs of rape victims can be met within them. If, however, these comprehensive approaches are still on the drawing board, short-term goals should not be neglected while waiting for the better solution to materialize.

c. *Coordination*. This is the most important of the functions necessary to an effective response to the problem of rape. This is particularly true with respect to improving the treatment of the victim, since she may be in contact with several law enforcement agencies and may need the services of mental health or social service organizations. For example, one of the problems most frequently complained of is that victims are asked to repeat their account of the rape to patrol officers, investigators, triage nurses, doctors, and several prosecutors. Another frequent complaint is that certain needs of the victim are left unattended because none of the agencies involved in processing a rape complaint undertake the responsibility.

In addition to the victim's needs, the interests of the criminal justice system are better served through coordination. For example, hospitals and prosecutor's offices need to collaborate on the design of forms used in the medical examination, and police may find it useful to have the cooperation of a rape crisis center which will refer victims to them and lend support to reporting victims who need help in order to continue with a prosecution.

Busy police officers, doctors, prosecutors, and counselors have little time for meetings and find them hard to schedule. For this reason the means by which coordination is to be accomplished becomes critical to its success. Often an administrative go-between is a necessity, at least until the essential elements of a community wide program are established.

d. *Monitoring*. Once each agency involved has an internal program, has developed lines of communication, and has mutually agreed upon procedures with other agencies, it remains to be seen how they work. Small misunderstandings and personality conflicts can jeopardize a program, particularly in the early stages before it is thoroughly institutionalized.

Simple self-assessment mechanisms should be built into every aspect of the program if there are no resources for independent evaluation. (See Appendix II.) A good way to monitor procedures developed to aid rape victims is to interview those who have used the system and services. When possible, it is also important to talk to victims who did not report the crime or call a rape crisis center and to learn what deterred them from doing so.

Monitoring helps to prevent backsliding, and it also provides a base of information from which further improvement can be developed.

2. *Structures*. Four types of structures have been used in communities that have organized to make changes:

a. *Ad hoc coalition of agencies*. This model has been used in St. Paul, Indianapolis, Chapel Hill, and, no doubt, in many small communities where appropriate personnel of the police department, hospital, and district attorney's office get together with representatives of citizen groups to decide how to improve their response to rape. To the extent that all participation is sincere and spontaneous, this may be the best structure within which to generate the cooperation needed.

Where the people involved have the authority to make necessary changes and already have positive personal or professional associations with each other, good results are quite likely. Unfortunately, ad hoc liaisons of this sort do not often take place among persons empowered to make final decisions, and they are often marred by specters of past interagency disputes. They are apt to be, therefore, both fragile and ineffective.

b. *Official task force*. A task force sponsored by the mayor, for example, has the advantage in most cities of being able to command the cooperation of municipal agencies. Of course, district attorneys are often elected, and one of a different political persuasion from the mayor may not be as anxious as others to cooperate. Some citizen groups might also react negatively. Still, official sponsorship makes investigation, evaluation, and monitoring all easier to carry out, gives more weight to the recommendations, and may improve the chances of acquiring financial resources.

On the other hand, while nominal participation is assured, some intra-agency enthusiasm for improvement may be dulled by having the obligation levied by higher authority, particularly if it appears that the official sponsor is using the activity for his or her image in the political arena. Moreover, some such task forces, such as the one established in the District of Columbia in 1972, simply make a report and recommendations and disband. To carry out the functions of coordination and monitoring, as does the Mayor's Task Force in New York City, the group must continue in existence and have the support of adequate administrative personnel.

c. *Criminal justice planning agency*. In several cities, such as Seattle and Denver, which have allocated LEAA Impact Program funding to rape-related projects, an officer of the criminal justice planning agency has performed all the necessary functions. In order to make grants, inquiries were made into current practices, and program objectives were drawn up. Grantee agencies usually cooperate with each other (sometimes through the mediation of the planner or program officer), and monitoring of the grantee's activity is part of the program officer's job.

Even where no funds were initially available, a planner in New Brunswick, New Jersey, organized the community's response to rape and on the basis of this success was able to obtain funding for a full-time coordinator.

This kind of structure has the same disadvantage as an official task force or any other group not directly involved with rape cases or rape victims and may also be less responsive to the community. Nevertheless, the fact that a professional is paid to carry out the coordinating functions, has access to funds which may be needed for improvements, and can use the lure of money to elicit cooperation should not be underestimated.

d. *Independent project*. There exists in San Francisco a fourth structural model. There the State Planning Agency made a grant to the Queen's Bench, an established association of women lawyers, to carry out a rape victimization project. The Queen's Bench hired a staff to look into the city's system for processing a rape case and for support to the rape victim. A report and recommendations were completed in less than a year, and the beginnings of a coordinating, monitoring, clearinghouse, and technical assistance capability were established.

If this project receives further funding, its appropriateness and effectiveness in providing a link between and assistance to the agencies and citizen's group can be assessed. It obviously shares with other models the disadvantage of being an "outside group." Unless it can become an "insider" by taking over some of the tasks that the others cannot or do not wish to do, it may never have their full cooperation. It also lacks the control of funds which the planning agency has to some degree and may even be seen as diverting funds that would otherwise have gone to the police, prosecutors, hospitals, or counseling centers.

APPENDIXES

APPENDIX I-A

GLOSSARY FOR POLICE SECTION

GLOSSARY FOR POLICE SECTION

The following definitions have been compiled for persons unfamiliar with law enforcement terminology.

Anonymous or third party report–Information on a rape case phoned in to the police by the victim or another person on behalf of the victim without revealing the victim's name and in lieu of filing an official complaint. Most departments reject such reports. A few, however, accept them in order to gain additional information about the number, location, time, etc., of rapes in their jurisdiction. Reports of this kind are neither investigated nor included in official statistics.

Audit trail–An examination of all police reports written on a specific case, plus an interview of the complainant, conducted by either the inspectional services unit or the supervisor of an investigation division. Audit trails are conducted to insure accurate reporting and to identify problems in the investigation for the purpose of upgrading the police response in future cases.

Chain (of custody) of evidence–The system by which custody of evidence is maintained so as to be able to account for the status of the evidence at every step from initial collection through storage, analysis, and eventual production in court. Evidence whose chain of evidence has been broken is not admissible in court.

Clearance rate–The proportion of all offenses known to the police which are either "cleared by arrest," "exceptionally cleared," or "unfounded."

Cleared by arrest–Cases closed by police by reason of the arrest and charging of the person(s) who there is probable cause to believe committed the offense(s) involved. In some departments the term is more loosely defined to include closed cases when the police have reason to believe they know the perpetrator but have not charged anyone.

Command post–The temporary headquarters of the patrol supervisor during the initial investigation of a crime, from which he/she directs patrol and support units in the search for a suspect.

Evidence technicians–Patrol officers who have had special training and are called off their regular duties to collect and preserve physical evidence at a crime scene. They generally work on cases other than homicide. Evidence technicians substitute for more highly trained lab technicians or detectives who cannot respond to a crime scene.

Exceptionally cleared cases–Cases closed by the police by means other than an arrest, i.e., when a victim refuses to cooperate in the investigation; when the prosecutor refuses to charge a suspect on grounds other than the insufficiency of the evidence; or when the case is out of the department's jurisdiction, either geographically or because the suspect is imprisoned in another jurisdiction.

Exculpatory evidence–Testimony or physical evidence tending to prove a suspect's innocence.

Formal victim statement–The victim's narrative, chronological account to an investigator of the offense reported to the police, but which may also take the form of, or be followed by, questions asked by the investigator about omissions or contradictions in this account.

The statement is generally transcribed, signed by the victim, and often becomes part of the case prosecution papers.

Liaison officer–(1) An officer who acts as an intermediary between the patrol force and the investigative bureau. His or her functions generally include issuing periodic bulletins, settling disputes, informing patrol officers of their case resolutions, and identifying patrol needs for training. (2) An officer who acts as a representative to hospitals or prosecutor offices to increase the flow of interagency communication and to improve interagency procedures.

Lookout–Information given to a patrol officer by a crime victim regarding the suspect's description, direction of flight, weapon, vehicle, etc., which the officer calls into the police dispatcher who, in turn, broadcasts it to patrol cars in the crime area. This signals the initiation of the search for the suspect.

Modus operandi (M.O.) file–A manual or, more rarely, computerized information file containing suspects' physical characteristics, methods of operation, crime types, and geographical and temporal variables. This type of file is considered to be an especially important suspect identification tool in sex crimes investigation because of the high rate of recidivism of a substantial proportion of known sex offenders.

On-street identification–Essentially a one-man lineup, this procedure allows the police to bring a suspect to the victim (and the victim to a suspect in some jurisdictions) for identification within a reasonable time after a crime is committed.

Out-of-service–The status of patrol officers who are involved in a service or crime call and, therefore, are temporarily unavailable to take another assignment.

Police reservist–Nonpolice personnel who receive training by the police to perform certain police functions. Their responsibilities generally include traffic and crowd control, clerical duties, report writing, and riding along in one-officer squad cars as extra personnel. They do not have police arrest authority. Reservists work part time, wear uniforms that differ from standard police dress, and are unarmed.

Protocol–A set of specific procedures followed by doctors, nurses, and social service agency personnel for the treatment of rape victims in hospitals.

Rape kit–A kit containing all the equipment necessary to collect, label, and store evidence obtained in conjunction with the medical examination of a rape victim.

Recidivist rapist–An offender who commits rape on two or more separate occasions.

Roll call training–Brief training sessions, usually conducted by a patrol supervisor, for patrol officers at the beginning of each shift (there are three shifts per day). The training generally consists of a short talk or film on a specific topic.

Support units–Department units that assist patrol in evidence collection, the search, and suspect apprehension during the initial investigation of a crime. Examples of such units are tactical squads, mobile crime labs or identification units, helicopter patrols, and canine squads.

Unfounded rape–A rape complaint determined by the police to be unsubstantiated by the evidence, after an admission by the complainant, or by extrinsic evidence contradicting her complaint.

APPENDIX I-B

CRISIS INTERVENTION AND INVESTIGATION OF FORCIBLE RAPE

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Crisis Intervention And Investigation Of Forcible Rape

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Crisis Intervention And Investigation Of Forcible Rape

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Katherine Ellison

THE TRADITIONAL FOCUS of the police has been on law enforcement: the solution of crime and the apprehension of offenders. However, it has become almost a cliché to point out that analyses of the police function reveal that they have increasingly fallen heir (estimated to occupy between 80 and 90 percent of their time) to an increasing array of important human service functions. Traditional training gives them few tools to aid them in performing these functions. If the police are to provide these human services in the manner most satisfactory both to the public and to the officer, it is essential to draw upon the knowledge in other fields related to human behavior. This does not mean that police officers should be made over into psychologists or social workers, rather it means that they should combine knowledge from these fields with their own unique experiences and expertise to perform all aspects of their job with maximum effectiveness, safety, and satisfaction.

Both law enforcement and human service functions are combined in an officer's dealings with a victim of forcible rape. This paper will deal with ways in which the police can use psychological knowledge both to benefit rape victims and at the same time to enhance their ability to apprehend offenders and close their cases satisfactorily.

The handling of rape investigations with psychological insight not only benefits the victim in terms of future psychological functioning, but also results in greater job satisfaction for the officer. In addition, it has ramifications in a larger sphere: "the word gets around," and an image is projected to the public of an authority with psychological and technical competence. This must lead not only to greater public cooperation but also to a greater sense of security for the public at large.

CRISIS THEORY: THE BACKGROUND

The body of psychological knowledge known as crisis theory is particularly useful in enlarging an officer's understanding of the victim's psychological state and reactions, of the way the victim views the situation, and of the officer's role in relation to that event.

Modern crisis theory had its origins in 1942 when a Boston psychiatrist, Erich Lindemann, and his colleagues from the Harvard Medical School, became involved with the victims and the families of victims of the Cocoanut Grove fire.[1] This terrible nightclub conflagration, in which almost 500 lives were lost and many more people were badly hurt, had a major impact on the city of Boston.

Lindemann's work with survivors, their relatives, and friends, produced many ideas about how to deal with victims in crisis. This work has been enlarged and elaborated on by other researchers in the field. Much of the work that has been done has dealt with people in psychiatric crises, while practical applications in other areas have been slower to develop. This paper will suggest that crisis intervention theory has particular relevance to the police especially in their interactions with the victims of crimes against the person, particularly the crime of forcible rape.

CRISIS AND ITS ASPECTS

Crisis may be interpreted in a wide variety of ways, but common to most definitions is the idea that it is a turning point in a person's life. *It is a subjective reaction to a stressful life experience, one so affecting the stability of the individual that the ability to cope or function may be seriously compromised.* Crisis comes in many kinds and degrees. An event that may be of crisis proportions for

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[1] Lindemann, E. Symptomatology and Management of Acute Grief. American Journal of Psychiatry, 101, 1944.

one person may have less effect on another, but there are some situations that may be considered crisis inducing for any individuals who experience them.

Crime victimization is one of the most stressful events in life. While it is not usually seen in crisis terms, it has all of the qualities that make for crisis. People tend to react to crime with the behavior that one sees in other, more obvious, crisis-inducing situations.

As every officer realizes, people respond differently to having been victims of crime. While highly personal reactions to stress make it difficult to suggest a formula approach to people in crisis, it *is* possible to define some aspects of a situation that will typically be perceived and reacted to as a crisis. It may be useful to discuss important characteristics of stressful situations that result in a crisis reaction.

A. Stress

1. *Suddenness.* Stressful life events that are sudden tend to have a crisis impact. When a situation comes on slowly, people are able to readjust their psychological defenses slowly to cope with it. The death of a loved one who has been dying slowly over months or years usually has less crisis impact than a sudden, unexpected death.

2. *Arbitrariness.* A situation that is arbitrary usually is experienced as a crisis. This is the sort of situation that seems unfair, capricious, and highly selective; it seems to happen in a no-fault, "out of the blue" way, resulting in the "why me?" phenomenon. An out-of-control auto selectively hitting one pedestrian in a crowd is an example of arbitrariness.

3. *Unpredictability.* Closely tied to arbitrariness and suddenness is unpredictability. In everyone's life there are normal and predictable developmental crises for which one can plan: marriage, a new job, a school examination, elective surgery, or any number of other events that are stressful but that can be predicted as being such with greater or less accuracy. Crises that can be anticipated lend themselves to planning so that some of the severity of the impact may be reduced. On the other hand, there are those crises which cannot be predicted. They are precipitated by wholly unforeseen events such as natural disasters, serious accidents, or crimes. It is the unpredictable that further confounds and complicates the stressful event leading to a crisis reaction.

B. Reactions to Stress

1. *Disruptiveness.* A crisis reaction has the characteristic of disrupting normal patterns of adaptation. Normally all of us have defenses which operate all the time to preserve the sense of "self," that is, to protect the self against the normal ebb and flow of life's events. We stay on a pretty constant course that way. But under the impact of a crisis-inducing situation, those defenses are disrupted and functioning suffers. Sleeping and eating patterns may become disturbed, work inhibitions may develop, attention and concentration become difficult.

2. *Regression.* Often individuals regress, that is, emotionally they revert to a state of helplessness and dependence that characterizes an earlier stage of development. When in a crisis, an otherwise mature and effective person behaves almost like a child in seeking support and nurturance, guidance, and direction from those regarded as strong and dependable.

3. *Accessibility.* With characteristic defenses disrupted in a state of helpless dependency, individuals in crisis are extraordinarily open and suggestible. This provides a unique opportunity to affect long-term outcomes.

One of an individual's most basic needs at this time is to ventilate feelings—to be able to talk about what has happened, to "get it out of your system." At this point sensitive intervention can help the person work through turbulent feelings about the experience and can minimize the long-term damage to psychological functioning.

If there is insensitive intervention that discourages ventilation, the individual quickly regroups his defense mechanisms and attempts to use them, often in extreme forms, to deal with the crisis. The defenses, instead of being appropriate reactions to a crisis situation, might harden into inappropriate habit patterns. For example, a common defense mechanism found in victims of crime is repression; they "forget" what has happened to them and can give only the barest, most confused details to the investigating officer. (One psychological theory tells us that this forgetting is only apparent and that the events continue to influence behavior.) Victims may tend to become paranoid and to feel someone is following them, or that the environment is dangerous, or that the offender is lurking nearby, even when this is not possible. They may develop nightmares, compulsions, or excessive, unreasonable phobias. Such defensive reactions often hinder not only the initial investigation, but also the successful legal pursuit of the case when the offender is apprehended and the case comes to trial. The person who "can't remember," who refuses to leave his or her room, and who fears all strangers can hardly be an ideal witness.

The disruption that occurs with crisis may become apparent immediately or there may be a delayed reaction. A police officer often will see a victim of serious crime, such as rape, who seemed calm and unconcerned at the time, but who, three or four weeks later, will need psychiatric treatment or be hospitalized. She may even call the officer who investigated the case and complain of acute or chronic insomnia, or phobias, or that she is depressed and cannot stop crying, and the like. Because crisis-symptoms might not be evident immediately but may show up after some period of time, the officer must act as though the situation is of crisis-proportions.

CHARACTERISTICS OF SUCCESSFUL INTERVENTION

Given the elements that make for crisis, the question then becomes, what are the basic elements that contribute to dealing successfully with a person in crisis? Specifically, what should a police officer do to help the person in crisis regain equilibrium while, at the same time, furthering his own work?

Police have several advantages as crisis intervention agents. Those who have worked with the crisis concept have emphasized the importance of earliness of the intervention. Being on the scene early allows one to take advantage of the period when the victim's defenses are down, when he/she is open and accessible to authoritative and knowledgeable intervention. The police officer is there early simply because people in crisis turn first to the police, especially when the crisis is precipitated by crime. Because the officer is on the scene first, actions taken can critically affect, either positively or negatively, the victim's subsequent behavior.

Almost as important as the immediacy is the question of authority. Most professionals in our society are seen as authority figures and their ability to perform their duties is enhanced by this aura of authority. Professional people are expected to be competent, to be able to do their jobs well. Because professionals are expected to be competent, those seeking their services act in ways that will facilitate this competency; for example, people listen and follow directions.

Some professionals have learned to take advantage of the public confidence that comes with authority. In the field of medicine, it is common knowledge that most of what a doctor cures has nothing to do with anything that is specifically wrong with people. At least 70 percent of the time of a general practitioner is devoted to functional disorders, i.e., with ailments that are basically psychological in origin. (Not unlike the 80 percent of police time being concerned with non-crime functions.) What people are cured by is a kind of laying on of hands. The doctor has come to have enormous authority in the eyes of people, and they turn to him for the satisfaction of psychological as well as physical needs. In the course of his training he learns how to use this authority in helping patients feel better.

Similarly, a police officer has considerable authority, both real and symbolic. The officer is the symbolic representation of everything from parent to the state. This is especially so when people are in trouble; people turn to the police to help in all sorts of difficulty, from a cat on the roof, to disputes with landlord or spouse, to emergency illness, to rape and robbery. Trouble is the business of the police, and society grants them much authority to help them deal with it. They must learn to use this authority. Because the police, by the nature of their job, have immediacy and authority, their behavior toward the individual in crisis must have impact upon both short and long-term adaptions of such people.

IS RAPE A SEX CRIME?

It is common to regard rape as sex crime. However, there is reason to question this view. Indeed, looking at it in the traditional way may well create a set in the police investigator's thinking that is dysfunctional. That is, to regard the act primarily as sexual in nature may distort the view of investigating officers, giving them a sense that they are dealing with something that really belongs in the area of morality. If one looks upon rape as a crime against the person, one may be more disposed to see it as one would view other aggressive crimes, such as robbery, assault, etc.

The difference in point of view may have a significant effect on the investigator's handling of the case. Despite the new morality, in our society sex is still a subject that is highly charged emotionally, and is difficult to deal with coolly and objectively. Even the most hardened officer, for example, often reports difficulty in dealing with the case of a child who has been sexually molested. The special feelings in our culture about sex are revealed by the fact that, in many states, laws dealing with sex crimes differ significantly from laws dealing with other crimes against the person. For example, a woman carrying a purse is ordinarily not considered to be "asking for" a mugging, but a woman in a short dress is often accused of "asking" to be raped. No other crime has such stringent corroboration rules or requires such blameless character and conduct on the part of the victim.

Recent research on rape[2] suggests that the intent of the offender is more often aggressive than sexual to prove his own masculinity and invulnerability by scapegoating and degrading the victim. Contrary to popular belief, the average rapist probably is not someone for whom normal sexual outlets are unavailable. Often too, the crime may follow a fight with a mother, a girlfriend or wife, and be a displacement of hostility against that woman.

RAPE IN THE CONTEXT OF CRIMES AGAINST THE PERSON

To understand the impact of rape, it would seem appropriate to examine it in the context of other crimes against the person as they are experienced by the victim. All crimes against the person can be said to be violations of the self[3] and, as such, precipitate crisis reactions.

A burglary is such a crisis-inducing violation of the self. People usually regard their homes or apartments as representative of themselves. In an important symbolic sense, their homes are extensions of themselves. It is, in the most primitive sense, both nest and castle. Particularly in a densely populated, highly complex environment it is the place that offers surcease and security. Each nest is constructed uniquely; each is different, just as individuals are different. When that nest is befouled by a burglary, it is not so much the fact that money or possessions have been taken, but more that a part of the self has been intruded upon or violated.[4]

In armed robbery, a somewhat more complex violation of self takes place. While in burglary, the victim is not directly involved, here the violation of self occurs in a somewhat intimate encounter between the victim and the criminal. In this crime, not only is an extension of the self (property, money, etc.) taken from the victim, but he or she is also coercively deprived of independence and autonomy, the ability to determine one's own fate. That is, under threat of violence, the victim surrenders autonomy and control, and his or her fate rests unpredictably in the hands of a threatening "other." This kind of situation must have a profound ego impact.

Now let us go a step further on the scale of violation of self to assault and robbery. Here there is a double threat: the loss of control, the loss of independence, the removal of something one sees symbolically as part of his "self," but now with a new ingredient. An injury is inflicted on the body, which can be regarded as the envelope of the self. The external part of the self is injured, and it is painful, not only physically, but internally in ego terms as well. Victims are left with the physical evidence reminding them that they were forced to surrender their autonomy and also of the fact that they have been made to feel like less than adequate people . . . a visible reminder of their helplessness to protect or defend themselves.

In this discussion we have moved from considering the implications of the violation of self as it relates to the extension of a person (burglary), to the loss of control and autonomy as well as part of the self (armed robbery), then to considering the insult to the envelope of the self as well as the loss of autonomy (assault and robbery). Now to the ultimate violation of self (short of homocide[5]), forcible rape. In the crime of rape, the victim is not only deprived of autonomy and control, experiencing manipulation and often injury to the envelope of the self, but also intrusion of inner space, the most sacred and most private repository of the self. It does not matter which bodily orifice is breached. Symbolically they are much the same and have, so far as the victim is concerned, the asexual significance that forceful access has been provided into the innermost source of ego.

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[2] Amir, Menachim. *Patterns in Forcible Rape*. University of Chicago: Chicago, 1971.

[3] The self is an abstract concept; sometimes called ego. It is the sum of what and who a person feels he is. A large part of the concept of self involves the body and the way one feels about the body, but it also includes such extensions of the self as clothing, automobile, and home. For example, this may be expressed in such ways as: "That's just the sort of house I'd expect him to have."

[4] This explains the sense of feeling "dirtied" often expressed by burglary victims. The intent to degrade is borne out by the fact that many burglars leave behind wanton destruction, and even, sometimes, deposits of feces.

From an ego-psychological point of view, this kind of forceful intrusion into interior space would have to be one of the most telling crises that can be sustained, particularly since it occurs in the context of the moral taboos which traditionally have surrounded the sex function. Indeed, to view rape as purely a sex crime encourages the search for possible sources of satisfaction in the experience for the victim. Actually, there is little opportunity for gratification in the context. For example, if one focuses only on the sexual, one would be tempted to minimize the effects of rape on women with considerable sexual experience. This is not the case. That is why promiscuous women or prostitutes, for whom sexual activity is certainly part of their normal adaptive pattern, will experience rape as a crisis. For all women the focus is upon the intrusion and the violation of self; even prostitutes, for whom sex is a commodity, there is a need to have a sense of control, a sense of autonomy. When this is taken from any woman, her defenses will be incapable of protecting her ego.

Adding to the victim's distress over violation is her awareness of cultural myths about rape, leading to fears of how friends and relatives will react toward her, and perhaps guilt feelings that she surrendered under duress, to a "fate worse than death." In this fearful, disrupted state, she sometimes comes to the police.

IMPLICATIONS FOR THE INVESTIGATOR

The implications of all this for police investigators are truly profound. If officers realize the crisis significance of rape and have an understanding of their role, particularly in terms of its immediacy and authority, they can be considerably aided in achieving a successful outcome of the investigation. Remember that an individual in crisis may be in a state of regression, and it is natural in such a state to try to defend the self by repressing the noxious experience. While regression provides an opportunity for fostering a relationship with the victim, repression may inhibit the communication of significant information.

A CASE HISTORY OF A RAPE SITUATION

Let us examine an example of a more-or-less typical rape case[6] and the way it was handled. Of particular interest are some of the crucial situations, how the police in this case handled them, what they did consistent with our understanding of crisis theory, and how they might have responded differently.

One Saturday afternoon an eleven year old girl, living in a large apartment complex in New York City, was accosted by a sixteen-year-old boy as she went into an elevator, was forced at knife point to the top of the building, and raped in the stairwell for half an hour. She was injured rather badly. When he left, she went down to the playground where she had been playing table tennis, picked up her racket, in a stunned manner, commented on the experience to two of her little girl friends, then went to her own building, took the elevator to her family's apartment, and told her mother about it. Her mother called the police. The police arrived quickly, questioned the family and the child with official demeanor, took the facts, and advised the family that detectives would be there shortly to conduct an investigation. They then advised a hospital examination and, indeed, took the child and her mother to the hospital which was not far away.

About two hours later, two detectives arrived, asked essentially the same questions that the original officers had asked, told the parents they would in touch again, and left.

Then the problems began. The child tried to talk about the event as the evening went on and both mother and father conspired to keep her from talking about it. The mother's guilt was operating; she experienced the event as having somehow been her fault. She had not protected her child, did not go down to the playground with her, did not keep an eye on her, etc. The father was enraged and guilty because he too had somehow failed to protect the child. There was a fifteen-year-old brother in that family who was also thrust into a state of crisis, and was being ignored. Why was he in a state of crisis? It was an event that had involved sex, an issue about which adolescents are particularly concerned. There was not much age difference between the two children; they were of different sexes, and there must have been some feelings. After all, incest taboos operate strongly in all families. And, additionally, the victim had reported that the rapist was about the same age as her brother. Thus the situation must have had serious implications for him.

What we see here is an incident in which the crime of rape has produced a crisis not only for the victim but for the entire family as well.[7] The impact of the crisis, its shattering effects, the regressive tendency of all members of this family cry out for a firm, gentle but knowledgeable authority who, by his actions, can satisfy the need for support and strength. And if this authority is a police officer, he can at this time set the basis for furthering his investigation.

For example, the parents might be approached in the following way: "Look, we're police officers; we've had experience with this sort of thing, and we understand. So let's talk about what our experience tells us is going to happen as a result of what's gone on here. You're going to feel more guilt than you may realize about what's happened to your little girl. You're going to ask yourselves, 'What could I have done to prevent this?' Well, in reality, you didn't do anything wrong, and neither did she, and there probably was nothing you could have done to prevent it. But we realize that knowing this is so doesn't keep you from feeling guilty all the same, and we understand that."

Just such a simple statement gives the message that this person with authority is knowledgeable and understanding and can actually predict and give voice to the gnawing internal experiences of these parents. Somehow this process is not only reassuring but encourages trust and an openness with the officer.

From there the investigators might go on to anticipate their future reactions so that the family and/or the victim can recognize them and deal with them as they occur. At the same time, they may set the basis for furthering the investigation. They might say something like, "We know that this is painful for the family, too. You're probably going to have a tendency not to want to hear about it, to feel that it would be best for everybody if your child didn't talk about it. But our knowledge in these situations tells us that people have a compulsive need to talk about what has happened to them, to 'get it out of their system,' to share it with someone who understands and who won't judge her or be harsh with her or blame her and says in effect, 'We still love you.'

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[5] Homicide, of course, is the ultimate violation of self. However, witnesses of the homicide or relatives of the victim are usually in a crisis state. The intervention techniques useful with the victims of crimes against the person are appropriate for use with these individuals.

[6] Contrary to public expectations, the majority of victims of rape are in their teens, and younger victims are common. Parenthetically, young male victims of sodomy are not uncommon either.

[7] This must be so in all cases; even if the victim does not tell her family about the crime, the changes that will almost inevitably be produced in her behavior as a result of the crisis will become obvious to those close to her. They will wonder what is wrong and be upset by these changes for which they can see no reason.

"Now, I want you to do a job for us. I would like you to listen to what she has to say, and if at any time in the retelling of the story there is a new piece of information you didn't hear before, write it down, and call us immediately."

In other words, these officers would not only be demonstrating to the family that they know what they are doing, but they have also given them a job to do in relation to the event. They have made them partners in apprehending the offender. The family members can feel that they can do some good in the apprehension, and at the same time they are doing the most helpful thing they can for the victim.

From the viewpoint of the investigating officers, this may seem the long way around. It implies that they should not try to get more than the barest facts at first, that the original report by the patrolman first on the scene probably is enough to begin with, and that probing at this point, especially aggressive probing, is more likely to be harmful and impede the flow of information than to be helpful.

So we would suggest that the first interrogation or interview be a very general one, a helpful one, one that demonstrates to the victim and her family that the officer is concerned about them. The emphasis is on the victim and on her family, not on the offender . . . not yet. First the victim must be allowed to "pull herself together," then she will be willing and able to deal with cooperating in the process of apprehending the offender. A realization of this priority establishes a relationship that will serve as a basis for gaining information. The investigators might even set up an appointment and say, "We'll be back next Wednesday, and we'd like to talk to you then and see how things are going. Maybe then you'll feel a little differently, and will want to go into the matter a little more." The situation is defined as one of helpfulness, not force, and the victim will repay with information and cooperation because the officers gave her and her family the support they needed in crisis.

In the long run, then, more information is likely to be gained with a little increase in time spent by the investigators. They have established a relationship of trust with the victim and with her family. Their desire to help reciprocally will also lessen the likelihood, so frustrating to the investigators, that if a suspect is arrested, the victim will refuse to cooperate, or that her family will put pressure on her to forget the whole incident.

FURTHER GUIDELINES FOR INVESTIGATION

We have attempted to present here a broad outline of how the theory of crisis intervention may be related to work with victims of rape. This outline has emerged from a blend of psychological theory and the practical experience of officers with whom it has been discussed. In discussing this outline with police officers who have dealt with rape cases, several more specific questions about the best procedures have arisen. In answer to the most common questions, some general guidelines may be presented that seem appropriate for the majority of cases. It is up to investigators, however, to realize that each situation differs and to use their discretion and intuition in determining when these suggestions are appropriate.

1. It is critical that the investigator scrupulously avoid any suggestion of force. This is especially true if the officer is male (and of course, most officers *are* male). Often, in his zeal to complete an investigation, because he is committed to what he is doing and really involved, the officer may be perceived by the victim as aggressive and forcible. In a sense, he is acting toward her essentially as the rapist had acted. The implication is obvious.

2. It is crucial that an authoritative investigator present himself in a benign, nonjudgmental way. This is especially true for the male officer. He must have patience and attempt to create a climate that will allow the individual to bring to the surface the information willingly and naturally. The extra time that this seems to take in the short run will yield more information in the long run because it tends to short-circuit repression.

3. The officer should encourage the victim to talk about what has happened, even though he may find it painful and threatening to have to listen. He may want to probe gently in a later interview for information that may be particularly shameful to the victim or that she may not know how to express. This is particularly true if some form of sexual abuse or sodomy, has or may have, occurred. The officer may say something like, "Very often women tell us other things hapened to them, too, things they consider unnatural or find hard to talk about. Did anything like this happen to you?" The officer must be careful, at the same time, not to suggest things to a victim who may lie or remember incorrectly in an effort to please him. A very gentle approach, perhaps a bit off-handed, not intense probing, may prevent the tendency to induce suggested conformity.

4. The most appropriate place for interrogation differs with the circumstances. No relationship or encounter occurs in a void. It happens in a setting and the setting often determines what happens in it. Generally, the home is the best place for an interrogation, especially if the rape did not occur there and the victim has not expressed a desire that her family not know about the crime. The home is the extension of the self, and if the interview can be done privately, within the home, it often adds to the victim's sense of safety and security. If the officer is in doubt it often is appropriate to ask, "Where would you feel most comfortable talking about this?" The station house usually is the worst place. It is an environment that is conducive neither to the sense of comfort nor of ease.

5. The question of place leads to the problem of the presence of others, and the necessity, often, of dealing with the family as well as with the victim. Most victims are part of a social network, and their reactions to a crisis will necessarily affect the way they relate to others, whether the others are told directly about the crisis or not. A victim may be afraid to tell her husband about the rape, but he cannot help but notice that her behavior has changed, that something is wrong, and this will, in turn, influence his behavior toward her, often in ways that make the crisis worse for her.

6. The victim always should be seen privately. Even the most well-meaning relative or friend will be upset by the situation and will tend to try to cut off the victim's need to ventilate. If the interview is in the home and the family members seem particularly anxious, it is sometimes helpful to interview the other members of the family first. This should be done without the victim in the room and for the purpose of assuring family members that both they and the victim are blameless. It is important that the authority make clear that the victim acted correctly because she is still alive. It is important, too, to reflect for them something of what they are feeling. They then may be enlisted as helpers in the investigative process.

7. If the victim comes to the station house alone to report the crime, she may want and need support in dealing with her family. It is appropriate to ask if she would like to be taken home and have the officer help her explain the

situation to her family. At any rate, given the nature of the social view of this crime, the meaning the crime has for the victim (i.e. violation of self), and the effect upon the person, it is very important that the privacy of the relationship with that immediate authority be uncomplicated by any other relationship. It should be developed in the context of confidentiality and closeness. If the officer establishes a good relationship with the family so that they understand the crime and its significance to the victim, then they have a way of dealing with the situation. This enables them to relate to the victim with the same sense of compassion and understanding that they have just received.

8. In later interviews, the officer assigned to the case may help the victim by de-mystifying the court procedure to her in a supportive way. He may also give her the names of organizations that have been formed to help the victims of rape. In New York City, for example, members of women's organizations familiar with the court procedure are available to supportively accompany the victim through the complexities of the legal process.

9. A frequently asked question is whether the officer assigned to the victim of a rape should be male or female. The reality in most police departments in this country is that the bulk of work is done by male officers. Even if one wanted to refer the victim to a female investigator such an officer may not be available. If the victim specifically and spontaneously requests a female officer, every attempt should be made to provide one for her. However, there is some feeling that there are advantages to having a sensitive male officer deal with the case. An understanding, supportive male at this time may help the victim overcome a natural aversive reaction to men. That is, she sees, at a time when such an experience is vital, that not all men are aggressive and harmful. This may ease her job of relating to the other men in her life. In any case, more important than the sex of the investigator is the individual officer's crisis intervention and investigative competence.

SUMMARY

In this brief presentation we have attempted to place the crime of forcible rape in the context of crisis theory. An understanding of human crisis and of crisis intervention techniques by an investigating police officer can immeasurably aid the rape victim in preserving her psychological integrity and also aid the investigating officer in the apprehension of the offender and in the preparation of a case that will stand up in court. ★

APPENDIX I-C

INTERVIEWING THE RAPE VICTIM

Interviewing the Rape Victim

The interview of a rape victim requires exceptionally intimate communication between the police officer and a victim who has been physically and psychologically assaulted. As such, the investigative nature of the interview represents only one dimension of the officer's responsibility. By conducting the interview tactfully and compassionately—and with an understanding of the victim's psychological condition—the officer can avoid intensifying the victim's emotional suffering. At the same time, the cooperation of the victim is gained and the investigative process is thereby made easier.

Training Key

#210

Law enforcement authorities agree that, for a number of reasons, rape is the most underreported crime in the United States. Because of the highly personal nature of rape, many victims are too embarrassed to report the crime. They would rather forget the incident than discuss it. In some instances, the rapist may be a relative or family friend, and therefore the victim is reluctant to file a complaint. Some victims do not contact the police because they fear that the investigative, medical, and prosecutorial procedures followed in a rape case are as psychologically traumatic as the crime itself.

The legal process that the rape victim encounters is unfamiliar to her and, under the circumstances, emotionally threatening. The police interview, in which the victim necessarily relives the crime by giving a detailed account of the rape and answers intimate questions, is followed by the courtroom trial where she can be subjected to an intimidating cross-examination by the defense lawyer. The legal process may take years to complete, constantly reminding the victim of the experience and making her relive it each time.

As the initial step in the legal process, therefore, the police interview should be more than an investigative inquiry. It should also be used to acquaint the victim with the complicated legal and medical system that she will encounter.

Important to the successful interview is the officer's understanding of the emotional condition of a rape victim. When interviewing a victim, the officer should not regard rape as solely a physical sexual assault. He should consider the psychological effects rape has on its victims. Often the lasting scar of rape is an emotional one, leading to marital problems, mental illness—even suicide.

Legal Elements of Rape

According to common law, there are three elements to the crime of rape when the female is over the age of consent: carnal knowledge (penetration), force, and lack of consent.

Penetration, as an essential element of rape, means that the sexual organ of the male entered and penetrated the sexual organ of the female. Court opinions have held that penetration, however slight, is sufficient to sustain a charge of rape. There need not be an entering of the vagina or rupturing of the hymen; the entering of the vulva or labia is all that is required. During the interview, the officer must clearly establish that penetration occurred with the penis. Penetration of a finger is not rape, although it is, of course, another form of assault.

The victim must have resisted the assault, and her resistance must have been overcome by force. The amount of resistance that the victim is expected to have displayed depends on the specific circumstances of the case. The power and strength of the aggressor and the physical and mental ability of the victim to resist vary in each case. The amount of resistance expected in one case will not necessarily be expected in another situation. It can be expected that one woman would be paralyzed by fear and rendered voiceless and helpless by circumstances that would inspire another to fierce resistance. There must be real, not token or feigned, resistance on the part of the woman before there can be a foundation for a rape charge.

Although there is no universal accord as to what degree of resistance is necessary to establish the absence of consent, the generally accepted doctrine is that a female, who was conscious and possessed of her natural mental and physical powers when the attack occurred, must have resisted to the extent of her ability at the time. Resistance is necessarily relative and the presence or absence of it depends on the specific facts and circumstances. Some women will have been so terrified that there will be no physical signs of resistance.

The kind of fear that would render resistance by a woman unnecessary to support a case of rape includes a fear of death or serious bodily harm, a fear so extreme as to preclude resistance, or a fear that would render her incapable of continuing to resist. On the other hand,

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consent, however reluctantly given, at any time prior to penetration deprives the subsequent intercourse of its criminal character of rape. There is, however, a wide difference between consent and submission to the act: Consent may involve submission, but submission does not necessarily imply consent.

In the absence of a statute requiring corroboration, common law generally holds that the unsupported testimony of the victim, if not contradictory or incredible, is sufficient to sustain a conviction of rape. Some states, in order to provide safeguards against unfounded accusations of rape, have laws that require corroborative evidence. Corroboration is supportive evidence that tends to prove that a crime was committed. It lends credence to the allegation that the crime occurred and needs not to be proved beyond doubt.

It is incumbent upon the police officer to obtain all possible corroborating evidence even if there is no statute requiring it. Corroboration of a rape offense can take physical forms such as semen stains on clothing, bruises, cuts, and medical evidence of sexual intercourse. It can be circumstantial, such as statements and observations of witnesses.

Although in some jurisdictions rape can be proved by the sole testimony of the victim, it is not common. Medical and scientific evidence is of prime importance and will frequently directly influence the successful prosecution of a case.

Psychological Reactions of Victims

That rape is intrinsically a crime of physical violence is explicit in its legal definition–"the having of unlawful carnal knowledge by a man of a woman, forcibly and against her will."[1] That it is more than that, however, is apparent from the reactions of rape victims, who in many cases sustain more psychological damage than they do physical injury.

SELF-CONCEPT: Except for homicide, rape is the most serious violation of a person's body because it deprives the victim of both physical and emotional privacy and autonomy. When rape occurs, the victim's ego or sense of self as well as her body is penetrated and used without consent. She has lost the most basic human need and right: control of physical and emotional self.

Perhaps most damaging to her self-concept is the intrusion of her inner space. Psychologically, it does not matter which orifice has been violated. Symbolically, breachment of any one represents to the victim a forced entry into her ego.[2]

Police officers should be aware that the rape victim has been forced to experience an event that, from her viewpoint, is emotionally asexual. The victim's psychological response to rape primarily reflects her reaction to violation of self. As such, it is extremely important that police officers view rape as an emotional as well as a physical assault.[3] This is true regardless of the moral reputation of the victim. Even prostitutes, who regularly sell their bodies, will experience the psychological violation of self when raped.

RESPONSE TO INTERVIEW: The way in which rape victims respond to the interview situation is varied, depending on their physical condition and individual psychological makeup. The verbal styles of the victims can range from quiet and guarded to talkative. Some victims find it extremely difficult to talk about the rape, perhaps because of the personal nature of the subject or because they are uncommunicative while under pressure. Others find relief in discussing the details of the rape. Often a victim will exhibit both patterns during the course of an interview.

The two verbal patterns frequently displayed by rape victims during an interview are indicative of general emotional states that are commonly associated with the psychological effects of rape. The victim may respond to the crime in an expressed manner: that is, she verbally and physically exhibits fear, anger, and anxiety. Or, the victim may respond in a controlled behavior pattern. In this pattern the victim hides her feelings and outwardly appears to be calm, composed, or subdued.

A number of rape victims will show their feelings through physical manifestations of expressed reaction. Crying, shaking, restlessness, tenseness–all are means of expression that accompany discussion of the crime, especially the more painful details. Some women may react by smiling or laughing. They do so to avoid their true feelings. Comments such as "really, nothing is wrong with me" combined with laughter serve as a substitute for the distressing memory of the attack.

Rape victims who are composed and able to calmly discuss the rape are usually controlling their true feelings. Presenting a strong controlled appearance during a personal crisis may be the way they cope with stress. In some cases, however, the victim's state of calmness may result from physical exhaustion rather than a conscious effort to remain composed. Because many rapes occur at night, victims are frequently exhausted, not having slept since the previous night.

A silent reaction on the part of the victim may also be encountered. The officer needs to realize that silence does not mean that the victim is hiding facts. It does mean that she is having a difficult time in starting to talk about the incident.

Another emotional reaction of rape victims is to express shock that the incident occurred. Statements such as "I can't believe it happened," "It doesn't seem real," or "I just want to forget it" are common psychological responses to the trauma of rape.

Although there is no doubt that general emotional reactions to rape vary among individuals, there does seem to be one common psychological denominator: fear. Experienced police officers have often observed that the victim has feared for her life during the rape, that she viewed the rapist as a potential murderer. In most cases, the emotional reaction to this fear does not dissipate by the time of the interview.

Regardless of the victim's emotional reaction and its observable manifestations to the crime, the interview itself creates additional anxiety. In many cases, the victim is totally ignorant of police procedures; perhaps she has never before talked with a police officer. The only certain thing is that she will have to discuss with a "stranger" the details of what is probably the most traumatic experience of her life. This produces a conflict within the victim: She *knows* that to make possible an investigation, the details of the rape must be discussed, but she *feels* apprehensive about describing the experience.

The character of the emotional stress that the victim experiences when she describes the rape is perhaps frequently misunderstood. To recount the details of the rape, the victim must mentally relive the incident. In most cases, the victim's psychological defenses will interfere with her ability and desire to remember what occurred. The victim may not be able to recall certain parts of the attack, or she may consciously change certain facts or omit them. The officer must exercise great patience and understanding in eliciting from the victim the necessary details of an experience she does not want to relive. Officers need to realize that this "reliving" of the experience, if not properly handled, can amount to a psychological rape of the victim.

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[1] Anderson, William S., Ed., *Ballentine's Law Dictionary*, The Lawyers Co-operative Publishing Co., Rochester, N.Y., p. 1054.

[2] Morton Bard and Katherine Ellison, "Crisis Intervention and Investigation of Forcible Rape", Police Chief (IACP, Gaithersburg, Md.) May 1974, p. 71.

[3] Ibid., p. 71.

Another important factor is that the interview should be thoroughly conducted. The officer should gather complete information during the in-depth interview; thus he avoids the need to repeatedly question the victim at later dates. This constant re-interviewing in effect requires the victim to relive the experience again and again. To avoid repeated interviews, the officer must overcome some victims' reluctancy and difficulty to talk by conducting a structured interview.

The Interview

The investigative goal of the police officer in interviewing a rape victim is to determine if and how the crime occurred. It is from the statements made by the victim to the officer that the essential elements of the offense and the direction of the investigation are established.

Because the interview process may be considered as a routine operation, the police officer may, if not careful, project the feeling of not being concerned with victim as a person. The danger is that the victim may be left with the impression that she is being treated as an object of physical evidence rather than as a person. The officer cannot allow this to happen. It is during the personal and sensitive communication of the interview that the victim's cooperation is gained and her emotional well-being is maintained. If the officer treats the victim impersonally, he will not gain her confidence and the interview will be unsuccessful. The officer may also cause the victim further emotional stress.

OFFICER'S ATTITUDE: When interviewing a rape victim, the officer must realize that, from the victim's viewpoint, what has occurred has not only been a violent sexual intercourse but also a perverted invasion of her self. Further, the officer must be constantly aware of his own sexual attitudes and the subtle and not so subtle ways in which they emerge. Special care should be exercised so that the rape victim is not placed in the position of perceiving herself as being guilty because of the personal nature of the crime and the social stigma attached to it. A professional bearing throughout the interview will help the officer obtain an accurate report of the crime without causing the victim to experience unnecessary anxiety.

PHYSICAL COMFORT: It is unreasonable to expect a rape victim to respond to detailed questioning while she is uncomfortable or in physical pain. The victim may have been beaten as well as raped. Frequently, the rape has occurred outdoors, and the victim and her clothing have been soiled. Sometimes the victim has been urinated on or has been forced to commit oral sex. Under conditions such as these, the preliminary interview should be brief, and the in-depth follow-up interview should be conducted after the victim has been medically examined and treated, and her personal needs such as washing and changing clothes have been met.

SETTING: The interview should take place in a comfortable setting where there is privacy and freedom from distraction. Places such as a crowded office where the interview is subject to interruption are inappropriate. A rape victim finds it difficult to discuss the intimate details of the crime with the interviewer; her reluctance to talk will greatly increase if there are other people present. She should be isolated from everyone. This includes friends, children, husband, boyfriends, and other victims.

It is often desirable that a policewoman conduct the interview. In some incidents, particularly with a juvenile, a rape victim can more easily discuss the crime with a woman than with a man. In most jurisdictions, however, use of a female officer is not possible. However, the police should consider the utilization of the presence of a trained female, such as a nurse or social worker, to help to ease the victim's embarrassment and anxiety.

OPENING REMARKS: To most rape victims, the interviewing officer is not just a police officer. The officer is also an official representative of society, probably the first representative met during a legal process that traditionally has placed a moral burden on rape victims. As such, the officer may symbolize to the victim the entire society. His behavior may represent to the victim the general attitude of the community toward her plight. If the officer is callous, accusatory in manner or speech, the victim may leave the interview fully expecting society—and perhaps even her family—to react in the same way. In addition, the victim may begin to, or further, question her own motives and therefore feel unnecessary guilt.

At this critical point, when the officer should presume that his attitudes are being expressed to the victim, he must gain her confidence by letting her know that a major part of his function is to help and protect her. He should make plain his sympathy for and interest in the victim. By doing this, the officer contributes to the immediate and long-term emotional health of the victim. He also lays the foundation of mutual cooperation and respect on which is built the effective interview.

"VENTILATION" PERIOD: Following the opening remarks, the officer should allow the victim to discuss whatever she wants. This "ventilation" period gives the victim an opportunity to relieve emotional tension. During this time, the officer should listen carefully to the victim, but he should be aware that any initial description of the incident may be colored by the trauma of the experience. Everyone's perception of reality is altered by extreme stress.

INVESTIGATIVE QUESTIONING: After the necessary ventilation period, the victim should be allowed to describe what occurred in her own words and without interruption. As the victim tells the story of the rape, she will also tell a great deal about herself. Her mood and general reaction, her choice of words, and her comments on unrelated matters can be useful in evaluating the facts of the case. It is important in such an interview that the police officer be humane, sympathetic, and patient. He should be alert to inconsistencies in the victim's statement. If the victim's story differs from the originally reported facts, the officer should point out the discrepancies and ask her to explain them in greater detail. The officer should phrase his questions in simple language, making sure that he is understood. It is best if the questions are presented in a manner that encourages conversation rather than implies interrogation.

Often the rape victim will omit embarrassing details from her description of the crime. Officers should expect a certain amount of reluctance on the part of the victim to describe unpleasant facts. The officer should explain that certain information must be discussed to satisfy the legal aspects of rape and pursue the investigation. He may add that the same questions will be asked in court if the case results in a trial.

In a majority of cases the attack is premeditated, and about half the time the rapist has known or has seen the victim before the assault. Because of this, certain types of questions should be asked.

The victim should be asked if, and how long, she has been acquainted with the offender. The circumstances of their meeting and the extent of their previous relationship, including any prior sexual relations, should be discussed. Although previous sexual acts with the accused will not absolve the offender at this particular time, knowledge of them helps to establish the validity of the complaint. Along these same lines, the officer should determine if the victim has ever made a charge of this nature in the past; review of previous records, if any, will provide insight to the present complaint.

Where it is determined that the victim had known the rapist prior to the incident, he should be identified and interviewed. If the offender is unknown, the officer must get a detailed description of him including clothing, speech, and mannerisms. The officer should determine whether the offender had accomplices or revealed any personal facts such as area of residence or places he frequented. Questions such as "Was anyone else present when first meeting or being attacked by the rapist?" should be asked. Did the offender use a weapon? What type? What kind of vehicle did he drive? After obtaining all the possible information about the unknown rapist, the officer will begin his search to identify him.

INTERVIEW'S END: As a result of having been raped, some victims suffer long-range emotional problems. At his discretion, the police officer may suggest that the victim seek assistance from an appropriate counseling agency, family physician, psychologist, or clergyman. In addition, the officer may explain to the victim's family the emotional suffering rape victims typically encounter.

Summary

From the information given by the rape victim during the interview is developed the investigative direction of the case. Without these facts, as personal and unpleasant as they always are to recount, police investigation of the crime cannot proceed.

The manner in which the interview is conducted is vital to the emotional health of the victim. The police officer should be aware that the rape victim has been assaulted psychologically as well as physically. In conducting all phases of the interview, he should keep the well-being of the victim uppermost in his mind by acting tactfully and compassionately.

Discussion Guide

1. In many rape cases, there is a brief *preliminary* interview with the victim that takes place at the scene of the crime or at the hospital. Discuss the purpose of this interview.

A. General Considerations
. . . Determine the nature of the crime.
. . . Identify suspect if possible.
. . . Broadcast a wanted message if possible.

B. Specific Considerations
. . . Administer first aid if required.
. . . Comfort the victim.
. . . Remain alert to signs of emotional stress.
. . . Use tact and compassion in asking basic questions about the rape.
. . . Determine if there is any physical evidence, such as hair, blood, or clothes of assailant, that should be collected.
. . . If interview occurs in home, ask victim to change clothing so you can preserve clothing worn at time of attack.
. . . If interview takes place at crime scene other than home, make arrangements for fresh clothing to be sent to hospital.
. . . Instruct the victim not to wash or douche before medical examination.

2. Rape is a psychological as well as physical act of violence. Review the general emotional reactions of victims that frequently are observable during the interview situation.

A. Verbal Styles
. . . Verbal patterns can range from quiet to talkative.
. . . Some victims find it difficult to discuss incident.
. . . Others are relieved to be able to talk about it.
. . . Often the same victim will be intermittently talkative and quiet.

B. Emotional States
. . . "Expressed" behavior–verbal and physical reactions, including fear, anger, and anxiety, are demonstrated.
. . . "Controlled" behavior–victim hides her stress and appears to be calm and composed.
. . . "Substitution"–victim laughs or smiles to avoid her true feelings.
. . . Victim is calm because of physical exhaustion.
. . . Victim expresses shock.
. . . Fear as common psychological denominator in rape cases.

3. Satisfying the legal requirements needed to sustain a charge of rape is a vital part of the investigative process. Discuss the following aspects:

...Penetration–must be with the penis
...Force–amount of resistance required varies depending on specific circumstances.
...Lack of consent–submission does not imply consent.
...Corroborative evidence is required in some states to sustain charge of rape.
...Regardless of state statute regarding corroboration, officer should seek corroborative evidence to strengthen case.

4. The follow-up interview of a rape victim is a delicate matter. Certain conditions should be met to make the situation conducive to discussion, to protect the victim from further emotional injury, and to conduct a productive interview.

A. Physical Comfort
...Victim has been attended to medically.
...Personal needs, such as washing and new clothes, have been met.

B. Setting
...Interview takes place where there is privacy and no interruption.
...Avoid physical barriers between you and victim if they interfere with interview.
...If possible, female officer conducts interview, or female nurse or social worker is present.

C. Preparation
...Thoroughly review all available information about the incident.
...Know what has been reported: names, places, descriptions.
...Check the police records for victim's involvement in criminal activities or previous complaints filed.
...When possible gather personal information about the victim.
...Be familiar with the crime scene and evidence gathered.
...Know the necessary elements of the offense and what facts need to be established.

D. Opening Remarks
...Officer symbolizes to victim her community's attitude towards her plight.
...Officer should not be accusatory.
...Officer gains confidence of victim by being sympathetic and putting her at ease.

E. Ventilation
...Victim relieves tension verbally.
...Officer should note remarks of victim in the emotional context.

F. Victim's Statement
...Allow victim to tell her story without interruption.
...Expect reluctance to immediately relate intimate details.

G. Investigative Questioning
...After she has stated the incident in her own words, the officer will need to ask questions to draw out the details.
...Explain that knowledge of personal details is necessary to pursue the investigation.
...The officer should put his questions in simple language, being sure he is understood.
...Tactfully point out discrepancies in victim's response, if any.
...Be alert to what is said and what is not said.
...Encourage conversation by open-end questions and the use of the long pause and by repetition of statements.
...Summarize what has been covered and ask the victim if anything needs to be added or emphasized.

H. Ending the Interview
...The officer should realize that some rape victims experience long-range emotional problems.
...If thought necessary, he should suggest to the victim to seek assistance from an appropriate agency, family physician, psychologist or clergyman.
...If possible, explain to the victim's family that she may encounter emotional difficulties and advise them to observe signs of trauma such as depression or withdrawal.

5. Throughout the nation special rape investigation units are being staffed with female officers. Many victims find it easier to talk to female investigators than to male officers. It would be desirable for every department to have female officers specially trained to handle rape victims; however, for the present time this is not possible in many agencies. Therefore, each officer, male or female, should be prepared to humanely handle a rape case, including the in-depth interview.

6. Women's anti-rape groups and police agencies are playing an increasingly active role in rape incidents. Discuss these developments and the police response to them.

A. Anti-Rape Groups
...These groups provide information to the victims about hospitals, treatment, legal matters.
...They may operate rape crisis centers and send a representative with the victim for support when she goes to the police or hospital.

B. Recommended Police Response
...Establish lines of communication to unify the range of services and procedures.
...Coordinate the many public and private groups as well as individuals involved.
...Document the extent of the rape problem in your jurisdiction.

7. To help combat and prevent rape, police departments can develop programs that inform the general public of the problems involved. Distribution of brochures outlining the preventive steps women should take to avoid being victimized and what to do if they are assaulted can reach a large cross section of the community. Representatives of the department can present lectures on the subject to social and professional groups and use radio or television to disseminate the information. In jurisdictions having a reputable anti-rape group, representatives of these groups should participate in the police public education program and even help train police officers in handling rape victims. Jurisdictions not having such a group probably could obtain assistance from a group in a neighboring city.

questions

The following questions are based on material in this Training Key. Select the best answers.

1. Which one of the following statements best describes the proper setting of an interview with a rape victim?

(a) A friend or relative should be present to calm the victim.
(b) The victim should be interviewed as soon as possible regardless of the location.
(c) The setting should be comfortable and afford privacy.
(d) Several officers should be present to witness the victim's statements.

2. In the context of interviewing a rape victim, what is meant by "ventilation?"

(a) Officer's attempt to get the victim to talk about the rape.
(b) Victim's substitution of true emotional reaction with laughter.
(c) Anxiety caused by discussing personal details of rape.
(d) Verbal release of tension.

3. If the victim knew the rapist before the attack, what can the officer assume?

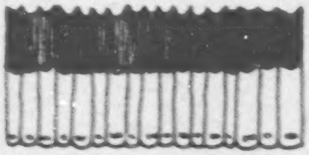
(a) Nothing.
(b) There was probably an element of consent during the incident.
(c) The victim is protecting her reputation.
(d) A rapist would not attack a woman who can identify him.

answers

1. (c) The interview should take place in a comfortable setting where there is privacy and where the victim feels free to discuss the personal details of the assault.

2. (d) Before the actual questioning by the officer, he should give the victim an opportunity to release tension by talking.

3. (a) Although the fact that the victim knows the rapist influences the direction of the investigation, at this point the officer can make no assumption based on such knowledge.



Have you read . . .

The Police Chief. "Police-Victim Relationships in Sex Crime Investigations." January 1970. International Association of Chiefs of Police, Eleven Firstfield Road, Gaithersburg, Maryland 20760.

The contention of this article is that the police by handling the victims of sex crimes with tact and courtesy can perform not only a real humanitarian service but actually do a better job of investigation.

The Police Chief. "Crisis Intervention and Investigation of Forcible Rape." May 1974. International Association of Chiefs of Police, Eleven Firstfield Road, Gaithersburg, Maryland 20760.

This article is a presentation of forcible rape in the context of crisis theory. Police officers employing crisis intervention techniques can aid the rape victim in preserving her psychological integrity.

APPENDIX I-D

ST. LOUIS POLICE DEPARTMENT SPECIAL ORDER: PROCEDURES FOR HANDLING RAPE CASES

This order is intended to clarify the functions of the sex crimes squad and the responsibilities of other officers working with (or substituting for) such a unit during the investigation of a rape case. The St. Louis order, already under revision, is presented here as a guide (not a model to be taken verbatim) from which principles can be adapted by other departments that have, or plan to establish, specialized sex crimes units.

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METROPOLITAN POLICE DEPARTMENT – CITY OF ST. LOUIS
OFFICE OF THE CHIEF OF POLICE
SPECIAL ORDER

Date Issued January 21, 1974 **Order No.** 74-S-3

Effective Date Immediately **Expiration** Indefinite

Reference

Cancelled Publications 73-S-39

Subject PROCEDURES FOR HANDLING RAPE CASES

TO: ALL BUREAUS, DISTRICTS AND DIVISIONS

INTRODUCTION

The crime of rape is a serious crime against a person which should be handled with sensitivity. Realizing the reluctance of some victims to discuss certain incidents with a male officer this Department has created a special squad consisting of male and female officers who have been given special training in the technique of interviewing victims of rape. This squad will be responsible for the follow-up investigation of reported rapes as outlined in this order and will be known as the Sex Offense Investigations Unit (SOIU).

PURPOSE

This order provides guidelines for the procedure to follow in the event of a reported rape.

I. RESPONSIBILITY FOR INVESTIGATION

The SOIU will have primary responsibility for the investigation of the following offenses except in death or critical injury to the victim which is the responsibility of the Homicide Section.

A. All Forcible Rapes

B. All Statutory Rapes

C. All Forcible Sodomy incidents with a female victim

D. Attempts at any of the above crimes

II. GENERAL PROCEDURES

A. If the incident is reported directly to an officer on the street

1. Take whatever immediate action is necessary to protect the victim and possible witnesses and the crime scene. Also, whatever immediate steps that may be necessary to effect the subsequent arrest of the perpetrator(s) (i.e. broadcast description of suspect).

2. Contact the dispatcher and request assistance from the SOIU and ETU.

3. Questioning of the victim should be kept to a minimum. Detailed statements and questioning will be conducted by the SOIU team.

4. Standby to assist the SOIU team in whatever manner is requested.

B. If the incident is reported by telephone it will be handled in accordance with existing Department procedures for calls for service.

1. Upon arrival at the scene of a reported incident which requires investigation by the SOIU team the initial responding officer will request the assistance of that unit and the ETU.

2. If the SOIU team is requested the officer at the scene shall take such action as needed to protect the victim and witnesses and the crime scene. He shall further take such steps as necessary to effect the immediate arrest of the perpetrator(s).

3. The officer shall then stand by to assist as directed by the SOIU team.

C. If the offense is reported directly to the SOIU, they will conduct the entire investigation.

III. MEDICAL ATTENTION FOR RAPE VICTIMS

A. The victim will be conveyed to a hospital immediately if

1. she requests immediate attention;
2. her injuries obviously require immediate attention;
3. the dispatcher advises that a SOIU team is not immediately available.

B. If the above conditions are not present the victim will be accompanied to the hospital by the female member of the SOIU team upon their arrival at the scene.

IV. EVIDENCE COLLECTION

A. Officers other than those assigned to the SOIU team or the Evidence Technician will not seize evidence, unless such seizure is needed to prevent the destruction or contamination of it.

B. The ETU will be responsible for the crime scene search and seizure of items of evidence.

C. The officer seizing any item of evidence will be responsible for the proper packaging of that evidence and its subsequent forwarding to either the Laboratory or Identification Division for analysis. (Refer to Special Order entitled "Evidence and Property Control Procedures")

V. REPORT PREPARATION

A. The Uniform Police Report (MPD Form 1) will be completed by the district officer including in the appropriate spaces the name and DSN of the Evidence Technician that responded and the clerk at the News Desk that was notified of this incident.

The narrative section of the report will contain the following information:

1. Time the crime scene was secured and by whom.
2. Time the crime scene was relinquished and to whom.
3. Pedigrees of persons detained.
4. That a further investigation is being conducted by the SOIU and a supplementary report will follow.

B. The district officer will make a full investigation and report if the SOIU team cannot respond. However, questioning of the victim relative to the act itself will be kept to a minimum.

C. The SOIU team will prepare a supplementary report in all cases they investigate except for offenses reported directly to the SOIU. In these incidents the SOIU shall prepare the Uniform Police Report and notify the district of occurrence. The name, DSN and rank of the person so notified will be included in the offense report.

VI. QUESTIONING OF VICTIMS

District officers will establish the nature of the offense and identity of the wanted subject(s). Detailed questioning of the victim concerning the act will be done by the SOIU and the statement obtained will be incorporated in a supplementary report prepared by the SOIU team.

VII. OFFENSES FROM OTHER JURISDICTIONS

Shall be handled by the district in the usual manner.

VIII. WANTED CARDS

A. Computer wanted records originated by the SOIU will contain the notation "contact SOIU" in the remarks section. The SOIU is responsible for the follow-up investigation when hits are made on these wanteds.

If a district originates a computer wanted record in which the SOIU conducts a follow-up investigation the SOIU team will cause the computer wanted record to be modified to show "contact SOIU".

B. Computer wanted records for cases prior to the inception of this squad, or which do not contain the notation "contact SOIU" will be referred to the originating unit.

IX. SOIU TEAM NOT AVAILABLE

A. In the event that an SOIU team is not available for an assignment when requested the following will adhere:

1. The investigating officer will conduct an investigation into the incident, request assistance of the ETU, and interview witnesses. The victim, however, will only be questioned to determine the nature of the offense and possible identity of wanted subject.

2. The officer will prepare the Uniform Crime Report (MPD Form 1) including the results of his investigation and the fact that an SOIU team was not available, per the radio dispatcher.

   NOTE: The dispatcher will maintain a list of requests for service for the SOIU when they are not available for assignment. The first available SOIU team will then be given these assignments and will be responsible for initiating the investigation by the SOIU.

3. The Command Post and Communications Division will be notified when SOIU teams are on standby. The Command Post will contact the team that is on standby if the need is urgent.

B. In the event the investigating officer feels that a policewoman is needed to assist, the procedures listed below will be followed:

   1. The investigating officer shall contact the Command Post and request the assistance of a policewoman.

   2. The Command Post personnel will then contact an on duty policewoman and notify her that the concerned district needs a policewoman to assist in the investigation of a rape.

   3. The district, upon receipt of notification from the Command Post that a policewoman is available from a particular unit, shall convey her from her location of assignment to the district to assist. The district will then provide transportation for the policewoman to her location of assignment.

   4. The policewoman, upon obtaining a statement from the victim will give this information to the investigating officer, who will incorporate her findings in his report. She will not be required The report to prepare a supplementary report.

X. THE SOIU SECTION

A. Will be composed of male and female police officers.

B. The female member of the team will be responsible for interviewing the victim.

C. The team as a unit will be responsible for

   1. Investigation at the scene.

   2. Preparation of necessary reports.

   3. Follow-up investigation of matters assigned by the unit supervisor.

D. The SOIU team will closely coordinate their investigations with district detective personnel who shall assist the SOIU team as requested for matters under investigation.

1. The SOIU supervisor will keep the district detective squad supervisor advised of the status of all investigations being conducted in their respective districts.

2. Any officer having information concerning a matter under investigation by the SOIU shall inform the SOIU team on duty of this information. In addition a memorandum will be forwarded through the appropriate channels to the SOIU with this same information.

By Order of:

Eugene J. Camp

EUGENE J. CAMP
Colonel
Chief of Police

EJC/rj:ps

APPENDIX I-E

EVIDENCE—SEX CRIMES CASES

EVIDENCE - SEX CRIMES CASES

Source:	Lt. Mary Keefe and Sgt. Harry O'Reilly Sex Crimes Analysis Unit New York Police Department
Purpose:	To provide members with the necessary information with which to process a reported sex crime case.
Procedure:	When being assigned to investigate or report a sex offense, process in accordance with department regulations and observe the following guidelines where appropriate.

General Rules

1. Safeguard crime scene.
2. Have Emergency Service, Photo Unit, or Forensic Unit respond and assist in crime scene search where appropriate.
3. Process for fingerprints.
4. Use caution not to damage, mark, or contaminate the evidence.
5. Put your identifying mark on evidence.
6. Document chain of evidence throughout investigation.
7. Place evidence in appropriate container and seal, prepare DD45A in triplicate, prepare property clerk invoice, deliver to crime laboratory.

Handling Evidence

A. Fingerprints

1. Handle objects carefully to avoid destroying possible fingerprints.
2. Wet objects must be allowed to dry naturally prior to processing. Do not use heat or fan to dry.
3. Do not place object in soft or pliable container--print may be smudged.

B. Stains

1 Clothing or fabric stained with paint, blood, semen, or other liquid -- submit the whole article, if practical.

2. If possible or practicable, circle stains with chalk, pen, or marking pencil while wet to facilitate locating the stained area when the liquid dries.

3. Allow wet stains to dry in the air -- do not use fans or heat.
4. Place clean paper over stain and place in a clean container. If necessary to fold, DO NOT fold across the stain.
5. Do not allow stained area to be placed in contact with unstained areas of the same garment or other garments.
6. If stains are on rigid surfaces which cannot be moved, allow them to dry and then scrape stain onto a clean piece of paper, package properly, and seal.
7. If necessary to improvise evidence containers, be sure they are clean and uncontaminated before inserting evidence.
8. Bear in mind that the color of dried blood may be red, brown, black, blue or yellow. Do not discount a stain as possible blood simply because it is not reddish in color.
9. Sealing material stained with bodily fluids in plastic containers causes putrefication and diminished evidentiary value. Each stained article should be packaged separately in brown paper (which is porous) and properly sealed and labelled.

C. Fibers and Hairs

1. Package separately to avoid contamination or damage to fibers or hair. Bending, crushing, or breaking may destroy valuable evidence.

At the Crime Scene

1. Collect undergarments, clothing, bedding, rugs or other appropriate items bearing semen or blood stains. Stains on carpeting should be cut out, leaving a border of unstained carpet for comparison purposes. If unable to cut out stain, scrape stain with a scalpel or razor blade and include scraping tool in envelope to be forwarded with the scrapings.
2. Collect torn clothing or bedding, broken objects or weapons which would tend to prove forcible compulsion.
3. Collect wash cloths or towels which suspect may have used to cleanse private parts. These may contain semen stains.
4. Collect bottles, glasses or other objects handled by suspect, which may contain latent prints. Prints may also be lifted from paper and from cigarette butts.

5. Search scene for foreign items such as buttons, hair, pieces of torn clothing.
6. If crime occurred outdoors -- Collect soil samples from scene, samples of vegetation, casts of footprints, for comparison against stains on shoes or clothing of suspect and victim. Take several soil samples and draw a sketch of area showing location from which sample was taken. In removing stains from soil, collect the crust and samples from nearby area. Label each sample.
7. If crime occurred in an auto -- Gather sweepings from seats and floors, search floor mats, seat covers, or blankets for stains. Check door handles for hair of victim or suspect if victim was forced to lie on seat or floor.
8. If entry was forced into victim's residence -- Gather samples of broken glass, paint samplings for possible comparison with suspect's clothing. Note jimmy marks and other appropriate burglary evidence.
9. Photograph crime scene, particularly where physical evidence is in view and where evidence of a struggle is present (furniture overturned, broken lamp, etc.).
10. Photograph bite marks, scratch marks, or other signs of injury to victim. Only a female police officer may take photographs of bruises or marks on the breasts, buttocks, or genital area of female victims. Have victim sign and date photos on reverse side.

Notes to be Prepared

1. Description of exact location where each piece of evidence was found.

   Examples: "One white brassiere, left strap torn, found on the ground in rear yard of premises 212 East 4th Street, 6 feet south of rear stairwell, 15 feet west of clothes line pole."

   or

   "One yellow terry cloth face towel, found on bathroom floor 4 feet from doorway, 2 feet from clothes hamper."

2. Description of victim's appearance and behavior.

   Note: Bruises or marks
   Disarrayed clothing
   Facial discoloration
   Smeared makeup
   Hair disheveled
   Confused or dazed behavior
   Bewilderment or disorientation
   Apparent hysteria or crying
   Attitudes of fear or remorse
   Incoherent or jumbled speech

3. Description of victim's clothing. Note locations of torn garments, semen or blood stains, dirt deposits, grass, vegetation or other stains.
4. Description of suspect. Physical description as provided by victim with special attention to items which would not be readily visible if the suspect were clothed (unusual undergarments, tattoos, scars, genital deformity, etc.).

At the Hospital

1. Ascertain that all signs of trauma or injury, as well as the emotional state of the victim, are recorded on the hospital examination report.
2. Ascertain that smears are taken from the vagina, anus, or mouth as appropriate.
3. Obtain slides from hospital personnel.
4. Obtain copy of hospital examination report. (If necessary, prepare a release to be signed by complainant which will authorize the hospital to provide a copy of their report to the Police Department.)

Arrest

When a suspect is apprehended within a reasonable time after the commission of the crime:

1. Search defendant and confiscate trousers, undergarments, and other appropriate clothing. Forward for testing for presence of semen or blood.
2. Search defendant's body for bite marks, scratch marks, or other injuries which may have been inflicted by the victim during the commission of the crime. Note and photograph such injuries.
3. Obtain search warrants if appropriate, to obtain clothing or other evidence, particularly if suspect has changed clothing since committing the crime.
4. Obtain Court Order to obtain hair or blood sampling if suspect refuses to give his consent.

   When appropriate -- Obtain for comparison purposes:

   1. Fingernail scrapings for victim vs. marks on suspect.
   2. Bite marks on suspect vs. cast of victim's teeth.
   3. Bite marks on victim vs. cast of suspect's teeth.
   4. Head and pubic hair samplings from victim and suspect. (Note: Obtain by combing rather than cutting. Submit a large number of hairs for most effective results. 100 hairs is the recommended number.)

5. Blood samples of victim and suspect.
6. Clothing of suspect and victim vs. buttons, cloth patches, or fibers found at scene.
7. Semen stains on victim or suspect for blood grouping.
8. Tape used to bind victim may be matched against roll from which it was torn or cut.
9. Cigarette butts smoked by suspect or spittle which he may have expectorated may be of value, since blood grouping test may be made of saliva.

Remember:

A sympathetic and supportive attitude displayed by an investigator towards a sex crime victim will instill confidence in the victim, overcome feelings of shame and embarrassment, and greatly facilitate the evidence gathering process.

APPENDIX I-F

NEW YORK POLICE DEPARTMENT SEX CRIMES ANALYSIS UNIT PERPETRATOR AND VICTIM INFORMATION FORMS

The following forms are presented here as models for the type of data necessary for modus operandi files on rape cases. Although these forms were designed for a computerized system, many of these variables can be included in manual card files.

SEX CRIMES ANALYSIS UNIT - PERPETRATOR INFORMATION FORM

Directions

1. Assigned detective prepare perpetrator and victim form. Circle appropriate number(s) in each category.
2. Prepare additional perpetrator form for each perpetrator.
3. When arrest is made, prepare supplementary report, completing boxes #40 through #60 on perpetrator form.
4. Forward via department mail to sex crimes analysis unit.

Note: Preparing officer begin at Box #7.
Boxes #1 and 6 FOR OFFICE USE ONLY.

(1)
SCAU # / / / /

(6) ______
CARD NO. 2

(7)
TOTAL NUMBER OF PERPETRATORS
OF THIS CRIME: /

(9)
THIS IS PERPETRATOR NO. /

(11)
SEX OF THIS PERPETRATOR
(1) Male
(2) Female

(12)
CRIME COMMITTED BY THIS PERPETRATOR:
(01) Rape
(02) Rape and Burglary
(03) Rape and Robbery
(04) Rape and Sodomy
(05) Rape, Burglary and Sodomy
(06) Rape, Robbery and Sodomy
(07) Attempt Rape
(08) Attempt Rape and Burglary
(09) Attempt Rape and Robbery
(10) Attempt Rape, Robbery & Sodomy
(11) Attempt Rape, Burglary & Sodomy
(12) Attempt Rape and Sodomy
(13) Anal Sodomy
(14) Attempt Anal Sodomy
(15) Multiple Sodomy (Oral and Anal)
(16) Oral Sodomy (Cunnilingus)
(17) Oral Sodomy (Fellatio)
(18) Attempt Oral Sodomy
(19) Multiple Sodomy (Cunnilingus and Fellatio)
(20) Sodomy and Burglary
(21) Sodomy and Robbery
(22) Sexual Abuse
(23) Sexual Abuse & Attempt Rape

(14)
AGE OF PERPETRATOR:
EXACT AGE, IF KNOWN: /

(92) Under 14
(93) 15 - 19
(94) 20 - 24
(95) 25 - 29
(96) 30 - 34
(97) 35 - 39
(98) 40 - 45
(99) 45 and over
(00) Unknown - Reason: ________
(Blindfolded; Mask; Not Seen, etc.)

(16)
RACE OF PERPETRATOR:
(1) White
(2) Black
(3) Light/Med. Hispanic
(4) Dark Hispanic
(5) Oriental
(6) Other ________________
(7) Unknown

(17)
HEIGHT OF PERPETRATOR:
(1) Under 5'
(2) 5' - 5'4"
(3) 5'5" - 5'8"
(4) 5'9" - 6'0"

(5) 6'1" - 6'4"
(6) Over 6'4"
(7) Unknown

(18)
WEIGHT OF PERPETRATOR:
(1) Under 100
(2) 100 - 124
(3) 125 - 149
(4) 150 - 174
(5) 175 - 199
(6) 200 - 224
(7) Over 225
(8) Unknown

(19)
MARKS/SCARS:
(1) Birthmark
(2) Freckles
(3) Moles
(4) Multiple
(5) Pimples/Blemishes
(6) Pockmarks
(7) Scars
(8) Other ____________

(20)
LOCATION OF MARKS/SCARS:
(CIRCLED IN COL. 19)

(1) Arm
(2) Face
(3) Hand
(4) Leg
(5) Multiple
(6) Trunk
(7) Other ____________

(21)
HAIR STYLE:
(1) Afro - Long
(2) Afro - Short
(3) Curly - Short
(4) Curly - Long
(5) Bald
(6) Partially Bald
(7) Kinky
(8) Special Cut (Styled)
(9) Straight/Long
(10) Straight/Short
(11) Unusual
(12) Unknown

(23)
HAIR COLOR:
(1) Black
(2) Blond
(3) Brown
(4) Grey
(5) Red
(6) Streaked
(7) Other ____________
(8) White
(9) Unknown

(24)
FACIAL HAIR:
(1) Beard
(2) Beard & Mustache
(3) Heavy Brows
(4) Long Sideburns
(5) Multiple
(6) Mustache
(7) Other ____________
(8) Unknown

(25)
EYE COLOR:
(1) Black
(2) Blue
(3) Brown
(4) Hazel/Green
(5) Maroon
(6) Mixed
(7) Unknown

(26)
DEFORMITY/UNUSUAL:
(1) Arm
(2) Ears
(3) Face
(4) Hand
(5) Leg
(6) Trunk
(7) Other ____________

(27)
TATTOOS:
(1) Arms
(2) Back
(3) Chest/Neck
(4) Fingers
(5) Hands
(6) Legs
(7) Genitals

(8) Buttocks
(9) Other ____________

(28)
COMPLEXION:
(1) Brown
(2) Dark
(3) Light
(4) Medium
(5) Tanned
(6) Other ____________
(7) Unknown

(29)
TEETH:
(1) Braces
(2) Discolored
(3) Gapped
(4) Gold
(5) Missing Lower
(6) Missing Upper
(7) Protruding - Buck
(8) Visible Cavity
(9) Good, Straight

(30)
VOICE/SPEECH:
(1) Accent - US Regional
(2) Accent - Other
(3) Very Low
(4) Stammer/Stutter
(5) Lisp
(6) Effeminate, Very High
(7) Gruff, Harsh
(8) Nothing Unusual
(9) Other ____________

(31)
CLOTHING:
(1) Business
(2) Casual
(3) Dirty, Sloppy, Torn
(4) Flashy
(5) Gang Jacket
(6) Well Dressed
(7) Uniform
(8) Other - Specify: __________
(9) Unknown

(32)
HEADGEAR:
(1) Bandana
(2) Baseball Cap
(3) Beanie
(4) Beret
(5) Fatigue Cap
(6) Fedora Type Hat
(7) Knit Hat
(8) Turban/Kerchief
(9) Wide Brim Hat
(10) Other ____________

(33)
JEWELRY:
(1) Brooch/Pin
(2) Bracelet
(3) Earring
(4) Eyeglasses
(5) I.D. Bracelet
(6) Medallion
(7) Necklace/Pendant
(8) Nose Ring
(9) Ring
(10) Other ____________

(34)
PERPETRATOR'S ACTIONS:
(1) Fetish
(2) Handcuffed
(3) Masturbated
(4) Sexual Abuse
(5) Threatened Children
(6) Tied Victim
(7) Verbal Abuse
(8) Other ____________

(35)
BEHAVIOR OF PERPETRATOR DURING THE ACT:
(1) Abusive Language
(2) Affectionate Language
(3) Apologetic
(4) Brutal
(5) Impotent
(6) Other Degrading Act
(7) Sadistic Behavior

(36)
BEHAVIOR OF PERPETRATOR UPON TERMINATION OF ACT:
(1) Apologized
(2) Fled Silently

(3) Gave Time Limit
(4) Suggested Future Contact
(5) Threat of Retaliation
(6) Verbal Abuse
(7) Other ________________

(37)
RELATIONSHIP OF PERPETRATOR TO VICTIM:

(01) Date
(02) Pick Up
(03) Hitchhiker
(04) Friend/Social Acquaintance
(05) Babysitter
(06) Relative (Immediate Family - Incest) (Father, Brother)
(07) Relative (Uncle, Cousin, etc.)
(08) Boyfriend/Girlfriend
(09) Business Relationship
(10) Same School
(11) Neighbor
(12) Has Seen in The Neighborhood
(13) Nickname Known
(14) Full Name Known
(15) Name and Address Known
(16) Co-Worker
(17) Landlord
(18) Total Stranger
(19) Unknown - No Information

(39)
UNUSUAL/ADDITIONAL INFORMATION:
(1) Drug User
(2) Alcohol User
(3) Gang Member
(4) Multiple (More Than One of The Above)
(5) Other - Specify: ________________

(40) thru (60)
Only if perpetrator is arrested - supply the following from arrest sheet and be sure to complete information under (A)

(A)
COMPLAINT # __________ PCT. __________

ARREST # ____________ PCT. __________

PERPETRATOR'S PLACE OF BIRTH

____

(40)
DATE OF ARREST:

/ / / / /
Mo. Day Year

(46)
SEX OF PERPETRATOR:
(1) Male
(2) Female

(47)
AGE OF PERPETRATOR: /

(49)
RACE OF PERPETRATOR:
(1) White
(2) Black
(3) Hispanic/Light
(4) Hispanic/Dark
(5) Oriental
(6) Brown
(7) Other
(8) Unknown

(50)
HEIGHT OF PERPETRATOR:
(1) Under 5'
(2) 5' - 5'4"
(3) 5'5" - 5'8"
(4) 5'9" - 6'0"
(5) 6'1" - 6'4"
(6) Over 6'4"
(7) Unknown

(51)
WEIGHT OF PERPETRATOR:
(1) Under 100
(2) 100 - 124
(3) 125 - 149
(4) 150 - 174
(5) 175 - 199
(6) 200 - 224
(7) Over 225
(8) Unknown

(52)
OCCUPATION OF PERPETRATOR:
(1) Clerical, Office
(2) Entertainer

(3) Factory Worker
(4) Food Service Worker
(Cook, Waiter, Etc.)
(5) Foreman
(6) Health Services
(7) Laborer (unskilled)
(8) Laborer (skilled)
(9) Manager, Administrator
(10) Mechanic, Repairman
(11) Police, Fire
(12) Professional & Technical
(13) Salesperson
(14) Service Worker
Custodian, Etc.)
(15) Steward
(16) Student
(17) Teacher
(18) Truck Driver
(19) Writer/Artist
(20) Unemployed
(21) Other ____________________

(54)
PERPETRATOR LIVES:
(1) In Precinct of Occurrence
(2) In Adjacent Precinct
(3) In Borough of Occurrence
(4) In Other Borough
(5) In New York
(6) Out of State
(7) Out of U.S.
(8) Unknown

(55)
PERPETRATOR WORKS:
(1) In precinct of Occurrence
(2) In Adjacent Precinct
(3) In Borough of Occurrence
(4) In Other Borough
(5) In New York
(6) Out of State
(7) Out of U.S.
(8) Unknown

(56)
MARITAL STATUS OF PERPETRATOR:
(1) Single
(2) Married
(3) Separated
(4) Divorced
(5) Widower
(6) Unknown

(57)
PREVIOUS ARRESTS FOR ANY CRIME:
1 2 3 4 5 6 (7) More Than 6 (8) None (9) Unknown

(58)
PREVIOUS ARREST FOR SEX CRIMES ONLY:
1 2 3 4 5 6 (7) More Than 6 (8) None (9) Unknown

(59)
INITIAL CLEARANCE:
(1) Unfounded
(2) Uniform Arrest
(3) Detective Arrest
(4) Arrest on Additional Charges
(5) Exceptional (O.R.)
(6) Closed - N.R.

(60)
IF CLEARANCE IS CHANGED SHOW NEW CLEARANCE:
(1) Unfounded
(2) Uniform Arrest
(3) Detective Arrest
(4) Arrest on Additional Charges
(5) Exceptional (O.R.)
(6) Closed - N.R.

SEX CRIMES ANALYSIS UNIT - VICTIM INFORMATION FORM

Directions

1. Assigned detective prepare perpetrator and victim form. Circle appropriate number(s) in each category.
2. Prepare additional perpetrator form for each perpetrator.
3. When arrest is made, prepare supplementary report, completing Boxes 40 through 60 on perpetrator form.
4. Forward via department mail to sex crimes analysis unit.

Note: Preparing officer begin at Box #12. Boxes 1, 6, and 7 FOR OFFICE USE ONLY.

(1)
SCAU # / / / / /

(6)
CARD NO. 1

(7)
ACME SUF # / / / / /

(12)
PRECINCT / /

(15)
COMPLAINT NO. / / / /

(20)
DATE OF OCCURRENCE

/ / / / / /
Mo. Day Year

(26)
TIME OF OCCURRENCE

/ / / /
Military Time

(30)
DAY OF WEEK:
(1) Sunday
(2) Monday
(3) Tuesday
(4) Wednesday
(5) Thursday
(6) Friday
(7) Saturday

(31)
WAS CRIME REPORTED:
(1) Within 24 hours
(2) 24 - 48 hours
(3) 49 hours to One Week
(4) One Week to One Month Later
(5) More Than One Month Later

(32)
NUMBER OF TIMES SEXUALLY ATTACKED BY PERPETRATOR:
(1) Once
(2) Twice
(3) More Than Twice

(33)
VICTIM'S SEX
(1) Male
(2) Female

(34)
VICTIM'S RACE:
(1) White
(2) Black
(3) Hispanic/Light, Med.
(4) Hispanic/Dark
(5) Oriental
(6) Other
(7) Unknown

(35)
VICTIM'S AGE:
(1) Specify: /

(37)
VICTIM'S MARITAL STATUS:
(1) Married
(2) Single

(38)
VICTIM'S OCCUPATION;
(1) Clerical, Office
(2) Entertainer
(3) Factory Worker
(4) Food Service Worker
(cook, waitress, etc.)
(5) Foreman
(6) Health Services
(7) Housewife
(8) Laborer (unskilled)
(9) Laborer (skilled)
(10) Manager, Administrator
(11) Mechanic, Repairman
(12) Police, Fire
(13) Professional & Technical
(14) Prostitute (known or admitted)
(15) Salesperson
(16) Service Worker (Custodian, etc.)
(17) Stewardess
(18) Student
(19) Teacher
(20) Telephone Operator
(21) Truck Driver
(22) Writer/Artist
(23) Unemployed
(24) Other ______________

(40)
VICTIM RESIDES WITH:
(1) Parents
(2) Spouse
(3) Family, Other Than Above
(4) Alone
(5) Roommate - Male
(6) Roommate - Female
(7) Children & Other Family
(8) Children Only

(41)
VICTIM INJURY:
(1) Beaten Seriously
(2) Choked
(3) Kicked/Slight Injury
(4) Punched/Slight Injury
(5) Slapped/Slight Injury
(6) Shot
(7) Stabbed or Cut
(8) Struck with Object
(9) Thrown to Ground
(10) Killed

(42)
MEDICAL ASSISTANCE:
(1) Refused Medical Assistance
(2) Treated and Released
(3) Private Doctor
(4) Injured/Outpatient
(5) Serious Injury/Hospitalized
(6) Homicide

(43)
VICTIM'S ACTIONS:
(1) No Resistance
(2) Physical Resistance - Successful
(3) Physical Resistance - Unsuccessful
(4) Verbal Resistance - Successful
(5) Verbal Resistance - Unsuccessful
(6) Used Weapon on Attacker
(7) Other ______________
(8) Multiple - Specify: ______________

(44)
VICTIM'S RESISTANCE OVERCOME:
(1) By Threat
(2) By Slight Force
(3) By Great Force

(45)
MEANS EMPLOYED BY PERPETRATOR:
(01) Hand Gun
(02) Alleged Gun
(03) Knife
(04) Alleged Knife
(05) Oral Threat
(06) Physical Force
(07) Chemical or Drugs
(08) Toy Gun
(09) Machine Gun/Shotgun
(10) Blunt Instrument
(11) Cutting Instrument
(12) Multiple Weapons
(13) Other: ______________

(47)
MODUS OPERANDI
CON STORY:
(01) Requested Information
(02) Requested Assistance
(03) Offered Assistance
(04) Offered Job

PRESENTED SELF AS:
(05) Delivery Man
(06) Interviewer
(07) Policeman
(08) Other City Official
(09) Repairman
(10) Other Con Story
____
(11) Break and Entry
(12) Forced Way Into House/Apt.
(13) Followed Victim Into Bldg.
(14) Grabbed Complainant
(15) Child/Adult
(16) Child/Child
(17) Taken to Perp. Residence
(18) Pick-up In Building
(19) Compl. Went Willingly to P/O
(20) Accosted with Weapon
(21) Performing Legitimate Service
(22) Other: ____________________
(99) Unknown

(49)
TREATMENT OF VICTIM:
(1) Kidnap
(2) Beat Complainant
(3) Raped in Front of
Compl. Husband/Boyfriend
(4) Raped in Front of Child/
Children
(5) More Than One Victim
(6) Fetish
(7) Other: ____________________

(50)
PREMISES ACCOSTED:
(01) Abandoned Building
(02) Alleyway
(03) Apartment
(04) Automobile
(05) Backyard
(06) Bar/Inn/Tavern
(07) Basement
(08) Beach
(09) Bus
(10) Bushes
(11) Church
(12) Clubhouse
(13) Day Care Center
(14) Driveway
(15) Dwelling
(16) Elevator
(17) Factory
(18) Garage
(19) Hallway
(20) Hospital
(21) Hotel/Motel
(22) Laundry Room
(23) Loading Platform
(24) Loft
(25) Massage Parlor
(26) Movie Theater
(27) Office/Business
(28) Park/Sports Arena
(29) Prison
(30) Parking Lot
(31) Restaurant
(32) Rest Room
(33) Roof Landing/Top
(34) School (Premises)
(35) Shed
(36) Stairwell
(37) Store
(38) Street
(39) Subway
(40) Subway Station

(41) Taxi (gypsy)
(42) Taxi (medallion)
(43) Truck
(44) Train/Bus Depot
(45) Vacant Lot
(46) Wooded Area
(99) Unknown

(52)
PREMISES OF OCCURRENCE
OF ACTUAL SEX CRIME:

Write in code number using
number 50 as a guide:

_______/_______________

(54)
INSIDE/OUTSIDE:
(1) Inside
(2) Outside
(3) Interior
(4) Accosted IPS, taken outside
(5) Accosted Outside, Taken Inside
(6) Accosted Outside, Taken IPS
(7) Accosted Inside, Taken Outside
(8) Accosted IPS, Taken Inside
(Note: IPS - Interior Public Space)

(55)
CRIME:
(01) Rape
(02) Rape and Burglary
(03) Rape and Robbery
(04) Rape and Sodomy
(05) Rape, Burglary and Sodomy
(06) Rape, Robbery and Sodomy
(07) Attempt Rape
(08) Attempt Rape and Burglary
(09) Attempt Rape and Robbery
(10) Attempt Rape, Robbery & Sodomy
(11) Attempt Rape, Burglary & Sodomy
(12) Attempt Rape and Sodomy
(13) Anal Sodomy
(14) Attempt Anal Sodomy
(15) Multiple Sodomy (Oral & Anal)
(16) Oral Sodomy (Cunnilingus)
(17) Oral Sodomy (Fellatio)
(18) Attempt Oral Sodomy
(19) Multiple Sodomy (Cunnilingus and Fellatio)
(20) Sodomy and Burglary
(21) Sodomy and Robbery
(22) Sexual Abuse
(23) Sexual Abuse & Att. Rape

(57)
NUMBER OF PERPETRATORS
OF THIS CRIME: 1

(59)
VEHICLE TYPE:
(1) Auto
(2) Bus
(3) Large Truck
(4) Small Truck/Camper
(5) Motorcycle
(6) Taxi
(7) Bicycle
(8) Other
(9) Unknown

(60)
VEHICLE MAKE:
(1) GM
(2) Ford
(3) Chrysler
(4) American Motors
(5) Foreign
(6) Other
(7) Unknown

(61)
VEHICLE BODY COLOR:
(1) White/Cream/Light
(2) Grey/Silver
(3) Gold/Yellow
(4) Red/Maroon
(5) Brown/Beige
(6) Black/Dark
(7) Green
(8) Blue
(9) Unknown

(62)
BODY STYLE:
(1) Sedan
(2) Hardtop
(3) Convertible
(4) Stationwagon
(5) Compact
(6) Sports Car
(7) Other ______________
(8) Unknown

(63)
WEATHER CONDITIONS:
(1) Seasonal, No Precipitation
(2) Rain
(3) Snow
(4) Exceptionally Hot
(5) Exceptionally Cold
(6) Foggy

APPENDIX I-G

FORCIBLE RAPE ON COLLEGE CAMPUSES: CHARACTERISTICS AND POLICE RESPONSES

FORCIBLE RAPE ON COLLEGE CAMPUSES: CHARACTERISTICS AND POLICE RESPONSES

A. Introduction

Forcible rape on college campuses has become a matter of increasing concern for students and university police. Increased crime on campus and the growing awareness of the problems associated with rape cases have encouraged some university police to upgrade general security measures and to establish specialized procedures for rape cases. In recent years students have also become more responsible for their own security by establishing their own safety programs.

In some cases, universities provide more comprehensive security measures for women than the larger community does. When a student is raped, she has the benefit of a free medical examination and treatment by college health facilities. In many universities, women's centers, rape crisis centers, and hotlines are available to assist and counsel rape victims. Despite these benefits, campus rape cases are complicated by multiagency police jurisdiction of investigations.

To determine the extent and nature of campus rape and the police procedures used in cases of forcible rape on campuses, approximately 20 university police departments were interviewed by telephone by project staff. These universities were selected because they were known to have instituted special procedures for rape investigation or prevention. While newspaper articles and references from knowledgeable persons led to some of these contacts, university police were the most helpful source of references to other departments. Of the university departments called, only 13 are discussed in depth, while others will be referred to for specific purposes only.

B. Caseloads and Characteristics of Rape on College Campuses

1. *The extent of campus rape.* The university police contacted in this survey reported between one and 12 rapes and attempted rapes on campus per year. The student population on these campuses ranged from 9,000 to 42,000, and, while no ratio of male to female students was reported, all these universities are coeducational.[1] (See Table 1.)

The national incidence of rape on university campuses is unknown. The FBI *Uniform Crime Reports of 1973* contains the offense rates from only 47 universities (66 campuses) totalling 100 rapes and attempted rapes. Even on individual campuses, it is unknown how many rapes are not reported to the police. University police generally believe that the unreported rate is high and that campus infirmaries see far more rape victims than do investigators. Most university health facilities are not required to report rapes to the police, but even when this is a requirement, most rapes can be hidden from the police. Rutgers, one of the two schools contacted that require their health facilities to report rapes to campus police, has the highest number of rapes reported in our survey. Yet, Michigan State, which also has this requirement, has the lowest. A Michigan State officer informed us that its campus facility claims to see a rape victim per day, but since women are seeking treatment without making official reports of rape to their doctors, these rapes never become part of the official statistics.

2. *The campus rapist.* University campuses serve as natural preying grounds for the rapist. Large concentrations of single, young women; easy access to campus grounds; and a variety of potential crime scenes (dormitories, empty classrooms, large open areas, etc.) make college campuses vulnerable to this type of crime. While campus police report that the modus operandi

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[1] Although references are made to Radcliffe College throughout this section, the university police jurisdiction is all of Harvard University.

TABLE 1

University/Campus	Student Population[1]	No. of Rapes[1] 1974	No. of Rapes 1973 (UCR)[2]	No. of Unfounded Rapes (1974)	No. of Investigators
Arizona State University	30,000	5-6	5	-	6 detectives 1 lt., 1 det. corporal
University of Colorado—Boulder	21,000	10	No info.	Infrequent	5 detectives (1 specialist)
University of Maryland	29,000	[3] 4	2	2-3	4 detectives (2 specialists)
University of Massachusetts—Amherst	28,000	7-8	No info.	2	Sensitive Crimes Unit 5 detectives, 1 sgt.
Duke University	9,000	5-6	No info.	-	3 detectives
Rutgers University—New Brunswick	35,000	12	No info.	-	4 detectives, 1 captain
Michigan State University	42,000	[3] 6	7	-	6 detectives (1 specialist)
University of California at Berkeley	30,000	6	6	-	5 detectives, 1 sergeant
Harvard University—Radcliffe College	15,000	1-2	No info.	Several	2 investigators
University of Wisconsin—Madison	37,000	1	4	-	6 detectives (1 specialist)
University of Florida—Gainesville	28,000	8	No info.	2	6 detectives, 1 chief investigator, (specialist)
Northwestern University—Evanston	10,000	5	No info.	-	2 investigators
Wayne State University	33,000	4	No info.	-	4 investigators

[1] Information obtained from university police officers.

[2] FBI *Uniform Crime Reports*, 1973.

[3] Rates are calculated on the basis of the fiscal year.

of campus rapists differ, their conceptions of the campus rapists are similar.

According to university police, the majority of campus rapes are committed by nonstudents from surrounding metropolitan areas. A spokesman at Rutgers described the typical campus rapist as a 35 year old who lives 25 miles from campus. An officer at the University of Colorado at Boulder reported that some of their rapes have been committed by men from Denver, and an Arizona State University officer claimed that some rapists are students, but that they are from college campuses other than A.S.U.

Most university police interviewed agree that the vast majority of campus rapes involve strangers or faint acquaintances. While this is undoubtedly a true evaluation of reported campus rapes, a large number of rapes involving persons known to each other probably go unreported to the police.

Unmarried university students are well within the age range of most rape victims and offenders and are at the age where most classical dating misunderstandings are said to lead to rape reports, yet few such cases are reported to university police. Even when some violence is involved, police believe that such rapes are not reported because the victims, living in a closed community where they and their friends know the offender and his associates, are under pressure not to involve the police or to create embarrassing situations for themselves.

Although campus rapists known to the police are strangers to their victims, few instances of rapes with multiple offenders are reported by college women. Only three schools reported that such rapes have occurred on their campuses, and only one school, Arizona State, reported two cases of kidnapping and attempted rape in the past year. The University of Florida at Gainesville and the University of Wisconsin at Madison reported rapes with multiple offenders only for years previous to 1974. Such incidents, they reported, generally begin on campus but move to scenes off campus.

More frequent than these cases are those involving recidivist rapists. Both the University of Maryland and the University of Kansas reported that one rapist was responsible for several rapes on campus.

3. *The setting for campus rape.* Many universities have increased security in and around dormitories in the past few years, but, according to all the police contacted, most rapes have not occurred in dormitories. Dormitories are usually more accessible to intruders than private homes or apartments because they have more interior public space and poorer locks, but students tend to know their neighbors better than apartment dwellers. Campus rapists bear less risk in dark, open areas, where there are no witnesses, than in college dormitories.

A frequent place of occurrence for rape, according to police at Wayne State, Northwestern (Evanston), the University of Maryland, and the University of Massachusetts at Amherst, is in academic buildings at night. Women with late classes in mostly empty buildings are often the targets of sexual assault on these campuses.

Other university police from Duke, the University of Colorado (Boulder), and the University of Wisconsin (Madison) claim that most campus rapes occur outdoors in open areas at night, while other police officers report that there is no one likely site for rapes on campus.

C. University Police Personnel and Training

Despite the small number of campus police investigators per university (see Table 1), several campus departments have elected to have at least one investigator specialize in sex crimes investigation. Although this is generally not a full-time job on college campuses, the practice shows concern for such investigations beyond that of many metropolitan police departments.

The University of Massachusetts at Amherst is the only school contacted that has established a special squad, the Sensitive Crimes Unit, to investigate sex crimes on campus. This unit not only handles its own cases, but assists and consults with other area colleges in sex crimes investigations.

University police investigators at Amherst and the five other departments specializing in rape cases have all received advanced training. Apart from standard in-service training, these officers have been sent to local schools holding seminars in rape investigation, and several investigators have visited metropolitan police departments having specialized sex crimes squads.

For the most part, these investigators exhibited an understanding attitude about rape and rape victims. No cynicism about the credibility of victims was expressed, nor were unfounded rape complaints claimed to be a major problem. Although this may be attributable in part to the lack of false complaints, it is also undoubtedly influenced by the training received by these investigators.

D. University Police Jurisdiction and Procedure in Rape Cases

It is impossible to discuss university police procedures without first considering their jurisdictional boundaries and authority. Because of their size, most university police departments must rely on city and county police to some extent in major crime investigations. In some measure, campus locations determine jurisdictional boundaries and university police official authority dictates the limits of investigative powers. However, formal and informal arrangements between campus police and other local police agencies may also determine investigative procedures.

1. *Patrol and preliminary investigation.* University police departments' jurisdictions vary both territorially and substantively. While all the departments contacted are responsible for patroling campus grounds, their other responsibilities vary. Some campus police patrol areas contiguous to the campus, but some go further into the community and share jurisdiction with a city, county, or state police department.

Some university police departments, such as those at Duke, the University of Kansas, and Northwestern (Evanston), have no jurisdiction off campus. At other universities, such as the University of Maryland, Wayne State, University of Massachusetts at Amherst, Arizona State, and Michigan State University, the departments' police powers outside campus range from local jurisdiction to statewide authority.

Most university police departments reported that their off-campus authority was used most often to pursue off-campus suspects who committed crimes on campus. For some departments, such as those at Arizona State and Amherst, no notification of local police is necessary when officers leave campus, nor must they notify local police of crimes committed on campus. Elsewhere, university police notify local agencies.

Jurisdictional lines of authority between campus and other police agencies are especially important in rapes committed on campus. They affect the victim directly because they determine how many officials she must deal with. They also indicate how much public attention may be brought to the victim on campus. Such lines of authority directly affect the amount of attention given to the case and may have a bearing on the outcome of the case, because they affect the amount and nature of the evidence collected.

On campuses where local police are notified immediately that a rape has been committed, such as the University of Kansas, the University of Chicago, Northwestern (Evanston), and Duke, local police come on campus to interview the victim. Since it is likely that campus police have been called first and arrive first, the victim will probably have to repeat at least part of her offense report to local police.

Similarly, where more than one police agency responds to a rape call, it is likely that more officers will arrive on the scene and more attention will be brought to the victim. For example, if a woman is raped at Radcliffe, at least one car and one supervisor are dispatched from both the university police and the Cambridge police, and it is likely that more officers will be dispatched. While this may not necessarily be important to students living off-campus, it is likely to be quite stressful to the victim living in a college dormitory.

Lines of authority will also determine what priority is given to the preliminary investigation of rape cases. For example, university police investigators at the schools contacted are more available for preliminary investigations of rape cases than are investigators in the metropolitan police departments surveyed for the handbook. All the university police contacted who have primary responsibility for the initial investigation of a rape case on campus, but who rely on local police to coordinate off-campus searches, dispatch investigators immediately to the crime scene or the hospital to meet the victim. Because of the small number of investigators in university police departments, this invariably means that investigators work on an on-call basis, and in some cases the investigators' supervisor or a sex crimes specialist is always on call. Such a system has been difficult for metropolitan police to institute because of union and monetary obstacles, but university police departments have fewer objections.

2. *Follow-up investigations.* Follow-up investigation of rape cases by university police closely follow the techniques used by metropolitan police departments. Identification of suspect methods—use of the Identikit, mug shot file, artist sketches, and lineups—are standard procedures. Where university police departments have few facilities or resources, as at Radcliffe, Duke, Arizona State, the University of Maryland, and Northwestern, city police take over one or more of these functions. Because most university police do not have modus operandi files for rapists (and those that exist are manual and incomplete), campus police usually rely on metropolitan police department files.

Unlike metropolitan police departments, where there is a split of opinion on whether formal victim statements are necessary, every university department contacted reported that victim statements are taken from student victims. Where campus police do not take the statements, as at San Diego State, Northwestern, Wayne State, and Radcliffe, city police take them. However, it was generally found that university police were more amenable to allowing a friend, relative, or rape crisis center representative to sit in on the interview while the statement is taken.

One university police department (the University of Colorado at Boulder) reported that investigators allow victims to write out their own statements. Among the metropolitan police departments surveyed, this procedure was only found in the Minneapolis Sheriff's Department. While writing the statement may be less embarrassing to the victim, metropolitan police departments say this is not a preferred practice because such statements often prove to be damaging to the victim in court. Invariably they contradict or omit information in other police reports or contain information inappropriate for court presentation.

When university police doubt the credibility of the rape victim, they are less likely to give her a polygraph test than are metropolitan police departments. Although these campus police do not have polygraph machines or operators, they could use those at other local police agencies. Nevertheless, only Arizona State police claimed some regular use of the polygraph for rape victims in suspicious cases (at the request of the county attorney), and the University of Colorado (Boulder) and Michigan State University reported this as an infrequent procedure.

Although several campus police departments collect physical evidence in rape cases, such as those at Rutgers, Berkeley, the University of Florida (Gainesville), Michigan State, and the University of Massachusetts (Amherst), evidence is generally turned over to the city police, sheriff's department, or state crime lab for analysis.

Clearance rates for rapes on the campuses surveyed vary greatly. There is no indication in the findings that either university police investigations or city police investigations lead to higher clearance rates. Rather, clearance rates more probably reflect the victim's ability to identify her assailant, the priority given to the investigation, and the ability of the university police to coordinate information and procedures with other local authorities.

E. Special Features of Campus Security

In addition to routine university police patrol of campuses and their surrounding areas, many schools have made special efforts to improve campus security. Improved lighting, emergency telephones, student security services, and crime awareness programs have become elements of many campus security programs. Some of these extra precautions relate specifically to protecting women from sexual assault, while others are more generally oriented.

1. *Student involvement in campus security.* Because the incidence of both property and personal crimes has been increasing on campuses, many students have been taking on more responsibility for their own security. While some student bodies have merely requested increased dormitory security or improved lighting, elsewhere student patrols and transportation systems have been established.

For example, Rutgers, Penn. State, and Wayne State universities have student patrols who work part time to supplement the university patrol force. Although these students do not have police powers, nor are they armed, they patrol (on foot) campus grounds and are supervised by the university police. Wayne State students also serve as receptionists in dormitories. The University of California at Berkeley police hire student aides for clerical duties only so that more police officers are available for patrol duty. While police at these universities report that they are satisfied with these student programs, one school, San Diego State University, reports that student patrols on campus will soon be disbanded because they do not provide adequate feedback to the campus police.

Students at other schools have developed transportation or "escort" services because they believe that walking at night or hitchhiking is unsafe. Although some of these systems were designed to protect all students, some were established specifically for women on campus.

The University of Florida at Gainesville's Student Nighttime Auxiliary Patrol (SNAP) program has combined patrol and escort services so that students patrol potential crime areas and dormitories, but provide transportation to students on an on-need basis. Other programs provide only escort services. For example, male and female volunteers of the student government at the University of Colorado at Boulder are equipped with a car to provide rides for students. Similarly, the Association of Student Government at Northwestern sponsors an escort service that runs until 1:00 a.m. Both of these programs are run with the cooperation of university police and with the help of police equipment, and they are welcomed by the students. Northwestern, for example, reports 40 to 50 requests for rides nightly. Only one school, San Diego State, reports that an escort service is operating without police assistance. There, fraternity men act as escorts to women on campus, but have no car at their disposal.

Escort systems are gaining in popularity and are likely to be replicated on many more campuses. Only two schools, Michigan State and the University of Maryland, have disbanded such programs.

One unfortunate side effect of these escort services alleged in the literature[2] and by some university officials contacted is that male escorts have also been rapists. Although no university police department contacted knew of such incidents on its own campus, several officers were dissatisfied with the lack of standards for selecting volunteers. While other schools use both males and females on their escort staffs, the University of Wisconsin Women's Transit Authority provides women drivers for women in need of transportation as one way to insure that rapes by escorts will not occur.

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[2] Andra Medea and Kathleen Thompson, *Against Rape - A Survival Manual for Women: How to Avoid Entrapment and How to Cope with Rape Physically and Emotionally* (New York: Farrar, Straus and Giroux, 1974) p. 4.

The other schools contacted reported no direct escort services. However, Radcliffe's shuttle bus service is geared to students' needs, and requests for rerouting and additional hours have been honored. This successful system transports about 2,000 passengers per week.

Where city transportation is poor and no escort services are available, some campus police will give rides to students under special circumstances. At least half the departments contacted reported giving occasional rides to students late at night, and one school reported that if their officers know women are alone at night at specific times and places on a regular basis, they will escort them home.

2. *Special equipment.* Several university police departments reported that lighting on campus has been improved over the past few years. Rutgers, Michigan State, Radcliffe, Northwestern (Evanston), Wayne State, and the University of Wisconsin at Madison have spent enormous sums of money to improve lighting. Mercury vapor lights have been installed on some campuses, while other schools have increased their lighting. Only at the University of Colorado at Boulder have campus police complained that lighting on campus is poor and that their requests for improvement have been ignored.

Several universities have placed emergency telephones in strategic positions on campus. Newer models of these phones, installed at Northwestern, Radcliffe, the University of Colorado, Wayne State University, and the University of Chicago, only require the receiver to be taken off the hook for a signal to flash on at headquarters to alert campus police that help is needed.

This security device, however, will probably not be used frequently by rape victims. According to university police, the vast majority of student victims do not call the police immediately after the offense, but first call a friend or family member for support. These emergency phones should be more helpful if police can persuade potential victims to use them when they suspect they are in danger, are being followed, etc.

3. *Educational programs.* Every university police department contacted reported that it conducts crime awareness programs for students. Most often these consist of lectures and films about crime prevention on campus and are given to dormitory students at least once a year.

Several departments speak to students specifically about rape and procedures in rape investigation. These presentations often include discussions of self-defense techniques and may be supplemented with pamphlets on rape prevention. Several officers also reported that self-defense courses will be offered for credit.

E. Concluding Remarks

The information presented here was gathered from standardized telephone interviews of university police officers, and it was not confirmed by on-site visits, as was the information about metropolitan police departments. Thus, there has been no way to determine how various departments may modify the formal police procedures they described over the phone. Furthermore, many of the local police agencies with which these campus departments work were unfamiliar to the survey staff.

Although these findings must, therefore, be considered preliminary, a number of observations can be made. For example, it is evident that most of the university police departments surveyed are making concerted efforts to give high priority to rape cases and to deal with victims with understanding and sensitivity.

Furthermore, because the size and resources of many of these departments approximate those of small municipal police agencies, some of the practices and procedures enumerated in the text may be applicable to them. Having one investigator specialize in sex crimes investigation, for example, is one approach that could be effective for small departments at no extra expense. The flexibility shown by many university police departments in cooperating with local agencies for rape investigations is a model that small departments are well advised to follow.

Much information about campus rapes remains unknown. There is every indication that many rapes are not reported to the campus police, and there is little information about the type and extent of these rapes. Additionally, little is known about the sophistication of rape investigations conducted by multiple police agencies. Neither the nature of victim treatment nor the quality of evidence collection and preservation in these investigations has been studied for its effect on rape case resolutions.

APPENDIX I-H

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SELECTED BIBLIOGRAPHY

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APPENDIX II-A

COMPENSATION FOR THE VICTIMS OF CRIME: LEGISLATION AND STATE ACTS

COMPENSATION FOR THE VICTIMS OF CRIME: LEGISLATION AND STATE ACTS

Twelve states have enacted legislation providing compensation for victims of crime, which may affect rape victims. Alaska, California, Georgia, Hawaii, Maryland, Massachusetts, Nevada, New Jersey, New York, Rhode Island, and Washington state have statutes approximating the provisions of the 1974 U.S. Senate Bill No. 300 "Compensation for Victims of Violent Crimes." That national bill reached the House Judiciary Committee, where it was referred to a subcommittee and died without being reported on.

The state victim compensation act names and years of passage are as follows:

Alaska	Violent Crimes Compensation Board	1972
California	Victims of Crime (revised)	1965 (1974)
Georgia	Claims Advisory Board	1967
Hawaii	Criminal Injuries Compensation Commission	1967
Maryland	Criminal Injuries Compensation Act	1968
Massachusetts	Compensation of Victims of Violent Crimes	1967
Nevada	Payments to Victims of Crimes	1969
New Jersey	Criminal Injuries Compensation Act	1971
New York	Crime Victims Compensation Board	1965
Rhode Island	Criminal Injuries Compensation	1972
Washington	Victims of Crimes–Compensation	1973

None of these statutes deal specifically with the compensation of rape victims. Only New Jersey, Rhode Island, and Hawaii define "injury" to a victim as including pregnancy. In addition, there are three main problems with provisions in most of these statutes as they may pertain to rape victims:

- Prerequisites for compensation often cite a minimum out-of-pocket expense and/or the incurrence of financial hardship as a result of the crime;
- The absence of specific provisions for nonphysical injury such as pain and suffering; and
- The victim's provocation of the accused as a determining factor in awarding compensation.

Financial Prerequisites

Typical of the five states (California, Massachusetts, New Jersey, New York, and Maryland) which require minimum claims and a showing of financial hardship is the Maryland statute:

> "No award shall be made on a claim unless the claimant has incurred a minimum out-of-pocket loss of one hundred dollars or has lost at least two continuous weeks' earnings or support. Out-of-pocket loss shall mean reimbursed and unreimbursed expenses incurred for medical care or other services necessary as a result of the injury upon which such claim is based." (Sec. 7)

The statute also requires:

> "If the Board. . .finds that the claimant will not suffer serious financial hardship, as a result of the loss of earnings or support and the out-of-pocket expenses incurred as a result of the injury if not granted financial assistance pursuant to this article to meet such loss of earnings, support, or out-of-pocket expenses, the Board. . . *shall* deny an

award. (Emphasis added.) In determining such serious financial hardship, the Board. . .shall consider all of the financial resources of the claimant." (Sec. 12)

Washington, which modeled its "Victim Crime–Compensation" Act after the Workman's Compensation Board, is unique and requires no financial prerequisites.

Most rape victims will not be able to recover under victim compensation statutes containing financial prerequisites such as Maryland's because they suffered no *physical* harm.[1] In Maryland and California "victim" is defined by statute as one who suffers "personal physical injury," thereby eliminating compensation for mental health care or psychiatric counseling sought as a result of the rape. Only New Jersey's statute broadly defines "personal injury" as "actual bodily harm" including specifically "pregnancy and mental or nervous shock." (Sec. 54:4B-2.) The New York and Massachusetts laws are ambigious, but might allow recovery for nonphysical harm.

In an attempt to avoid flooding crime compensation boards with small claims by establishing a $100 minimum, the statutes fail to meet the needs of the poor who may be dramatically affected by an out-of-pocket loss well below the minimum. But on the other hand, criticism has been leveled at provisions requiring financial hardship as a basis for compensation, because they discriminate against middle class victims. Only the Washington law, which was designed to be a substitute for the civil liability of the state, emphasizes compensation, not need.[2]

Nonphysical Injury

With the exception of Hawaii, New Jersey, and Rhode Island, all the statutes fail to address the problems and expenses of pain, suffering, mental anguish, and nervous shock. Those states which do address compensation for nonphysical injury are vague and provide ambiguous guidelines at best for program administrators who must determine the extent of coverage awarded.

Hawaii, New Jersey, and Rhode Island recognize pregnancy as a compensable injury and thereby make recovery potentially available for medical care incident to pregnancy, delivery, and abortion. Theoretically, loss of earnings due to maternity could also be compensable.

Victim's Provocation of the Accused

All the statutes consider the possibility of the victim having provoked the accused. New Jersey's provisions are representative of how the statutes inquire into the question of provocation:

> In determining the amount of an award, the Board shall determine whether because of his conduct, the victim of such crime contributed to the infliction of his injury, and the Board shall reduce the amount of the award or reject the application altogether, in accordance with such determination, provided, however, that the Board shall not consider any conduct of the victim contributory toward his injury, if the record indicates such conduct occurred during efforts by the victim to prevent a crime or apprehend a person who had committed a crime in his presence or had in fact committed a misdemeanor. (Sec. 52:4B-18.)

The wording suggests extensive and potentially dangerous inquiry into the rape victim's background and could impeach her credibility in the eyes of the Board, or at least lessen their sympathy towards the victim.

The Proposed Uniform Crime Reparations Act would have eliminated the interpretative problems created by the terms "provocation, consent or any other behavior" and "conduct" of the victim by clarifying to whom compensation may not be awarded:

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[1] In 3/4 of the forcible rape cases, the victim suffers no physical harm, apart from the sex act itself. D. Mulvihill and M. Tumin, *Crimes of Violence*, 237 (1969), cited in Lamborn, "The Scope of Programs for Governmental Compensation of Victims of Crime." U. Ill. L.R. 1973:21-87.

[2] Cosway, "Crime Compensation," 49 Wash. L.R. 551(F.1974).

> Reparations may not be awarded to a claimant who is the offender or an accomplice of the offender, nor to any claimant if the award would unjustly benefit the offender or accomplice.

Conclusion

The first weakness in these statutes—the prerequisites for compensation—discriminate on the basis of wealth and type of expense. Failure to address nonphysical injuries and pregnancy, the second weak point common to the statutes, ignores the most frequent forms of harm resulting from rape. Requiring the Compensation Board to consider the victim's role of provocation of the crime is ambiguous and potentially prejudicial in the case of rape.

In the absence of federal legislation to fund state victim compensation programs, a number of states face severe funding problems and pressure to amend existing legislation. Several states have empowered commissions to administer programs which have no compensation funds to award. It would appear that further development of victim compensation acts will not take place until a national program and guidelines are established, and state criminal codes are overhauled.

APPENDIX II-B

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

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THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA
2007 Eye Street, N.W.
Washington, D. C. 20006

Report to the Executive Board

FROM: Lucia Gomez, M.D., Chairwoman DATE: March 20, 1974
COMMITTEE: Ad Hoc Committee on Sexual Assault Victims

Recommendations from the Ad Hoc Committee on Sexual Assault Victims to the Executive Board regarding the protocols for the care of alleged victims for approval and action are as follows:

That the proper legal measures (Corporation Counsel, Lt. Caldwell, lawyers of the D.C. Medical Society) be taken so as to make:

1. The reporting of alleged sexual assault to the police not be mandatory but voluntary on the part of the victim if patient is 16 years or older;

2. that medical care and treatment be given to the alleged victim regardless of reporting the incident to the police;

3. that in the absence of a parent or legal guardian, a minor 16 years of age or older be allowed to sign her own consent form for treatment of alleged sexual assault;

4. that the proper authorities clarify in writing as to who can act as parents or authorized guardians when a child who seeks help for alleged sexual assault does not want her parents or guardians when a child who seeks help for alleged sexual assault does not want her parents or guardian to know;

5. that the attached "Medical Protocol" and Follow Up Mental Health Protocol" for the medical care and treatment of alleged rape victims become the standard protocols in all hospitals in the District of Columbia;

6. that the necessary measures be taken to carry out the recommendations made in the "General Mental Health Protocol for Treatment of Victims of Sexual Assault" which we include here;

7. that the Department of Human Resources should either provide the funds itself or seek sources of funding to carry out the following:

A. all hospitals in the District of Columbia should be able to provide emergency care to sexually assaulted persons. The Department of Human Resources should negotiate with the following hospitals to designate them as official "Emergency Care Centers for Sexual Assault Victims":

1. D.C. General Hospital
2. Greater Southeast Community Hospital (formerly the Morris Cafritz Memorial Hospital)
3. Freedmen's Hospital
4. Children's Hospital of D.C. (restricted to victims under 18 years of age)
5. A fifth hospital is under consideration

and fund the above or any other participating hospitals, so as to be able to carry out all the recommendations of the proposed protocols without charge to the victim, if the victim has no third party insurance to cover for it.

B. to establish a Center for Assistance to Sexual Assault Victims as proposed by the Ad Hoc Committee.

8. that a form be drafted whereby a person 16 years or older who seeks medical care for alleged sexual assault, but does not want to report it to the police or press charges, releases the hospital from any responsibility for not collecting the evidence;

9. that the proposed protocol for "Long Term Follow Up of Alleged Sexually Assaulted Persons" be adopted;

10. that the existing court procedures be changed and instead the following legal issues pertaining to mental health be adopted:

A. because of the nature of the crime and the embarrassment to many of the victims, the court should not be opened to the public. A more private hearing would not affect the course of justice and it would minimize further emotional upheaval to the victim. This should be especially followed in the case of children and adolescents where the adversary system can be outrageously cruel and traumatic;

B. we should recommend the use of closed circuit television as an alternative procedure (a suggestion made by Councilman Meyers);

C. recommendations for changes in rape laws as outlined by the Rape Task Force that was submitted to City Council should be supported by us;

11. that these proposals be acted upon with expediency;

12. if the Executive Board approves these recommendations, it is requested that they make recommendations to the American College of Emergency Physicians, American College of Physicians, American College of Obstetricians and Gynecologists, and the American Nurses Association, to include in their annual meetings sessions on sexual assault including the protocols for acute and chronic follow-up treatment of sexual assault victims and encourage them to include expert people to participate in the programs.

[Signed]

Lucia Gomez, M.D., Chairwoman

COMMITTEE MEMBERS:

Charles F. Colao, M.D.

Charles R. Hayman, M.D.

Horace Laster, M.D.

Edward Weiss, M.D.

[The complete Medical Protocol for Alleged Rape Victims is available on request from the Medical Society of the District of Columbia, 2007 Eye Street, N.W., Washington, D. C. 20006.]

APPENDIX II-C

SUMMARY OF A PHYSICIAN SURVEY REPORT

SUMMARY OF A PHYSICIAN SURVEY REPORT

Linda S. McGuire, Ph.D.
April 24, 1974

DISCUSSION

[In responses to a questionnaire sent to 1,010 physicians in Kings County, Washington, in March 1974] 149 physicians reported treating 369 female victims of sexual assault during 1973. This represented one-third of the 523 respondents. Five hundred twenty-three represented slightly over one-half of the total population surveyed. It is felt that a 50% response in this type of a survey is a sufficiently large sample to warrant attention to the results. However, as it is an incomplete survey of the total population, one cannot make statements about the general population. For example, it could be hypothesized that the physicians not responding were those not seeing rape victims, and, hence, the figure of 369 seen by private physicians is quite accurate. However, it may be that those persons not responding treated as many or more victims than those reporting. (Late returns of the questionnaire tend to support the former hypothesis.)

As regards the [medical] specialities, most averaged a 50% return rate, with the exception of obstetrics and gynecology, internal medicine, and general surgery, who averaged a 37% return rate. General and family practitioners saw the greatest percentage of victims (52%). The number of victims seen by the physicians was not evenly distributed -- a relatively few physicians saw the majority of the victims, suggesting that the need for extensive outreach to the private sector would be most effective by concentrating on those persons who see most of the rape victims.

Contrary to the notion that women seen by private physicians constitute a vast hidden iceburg of unreported rapes, the majority of the women treated did report their sexual assault to the police (57%). In 15% of the cases, this information [whether the women reported] was not known to the physician, and, presumably, a certain percentage of these women chose also to report their rapes. A general feeling of willingness to cooperate with law enforcement agencies characterized physicians' responses to many items on this questionnaire. Only 37% would not support responses to many items on this questionnaire. Only 37% would not support mandatory reporting of rape. Seventy-five percent reported favorable impressions of police contacts in cases of sexual assault. Seventy percent stated that either they "strongly encouraged" or "encouraged" patients to report rape to the police. Sixty-eight percent denied being reluctant to testify in cases of rape. The fear of being called to testify may be somewhat exaggerated, as only 5% reported testifying more than once in a case of rape.

The global impression of the Information Section [This section asked the physicians, and students in an upper level psychology course, their beliefs about rape statistics. For example, one survey item was "Forcible rape rates during the past decade: increased somewhat; more than doubled; tripled; did not change."], is that approximately 60% of the physicians correctly answered each item. No striking differences were noted between physicians' responses and the responses of students taken together, or male students. Of the 10 questions presented, in five cases differences were found greater than 5%, and in five cases differences less than 5% were found. Of the five questions in which there were differences, the differences were of the following magnitude: 8%, 9%, 9%, 11%, 34%. The question in which the differences were most marked was #7 [What percentage of victims suffer physical trauma?]; this may have stemmed in part from wording, which failed to distinguish physical trauma (cuts, bruises) from forceful penetration. The difference probably also can be attributed to a popular conception of rape as a far more violent crime than it frequently is; 37% of the students felt that "physical trauma" occurred in between 76-100% of the cases of rape.

The responses of the female students departed from those of male students and physicians in the direction of overestimating the frequency of rape (e.g., 37% of the women felt that the proportion of women raped to the number of women reporting rape was 10:1, whereas only 20% of the male students and 29% of the physicians that estimate).

Women tended to ascribe more frequently to the statement that "trauma in sexual assault is greater than trauma associated with general physical assault." (Women students = 90%, Male students = 81%, Physicians = 68%). Women felt that emotional trauma following sexual assault might manifest itself after two months more frequently than did the other two groups. The general tendency in the pattern of female responses was to emphasize the duration and severity of emotional trauma that they believe is associated with sexual assault and to overestimate the incidence. This is no doubt a reflection of their greater sense of vulnerability and identification with the victim of sexual assault.

There was a general tendency for all groups to over, rather than underestimate the incidence of rape. A tendency was seen to stereotype the victims as white, and physicians overemphasized the role of the black male as assailant (18% vs 9% for all students). However, as above, the differences showed trends, but were not marked.

In summary, this section of the questionnaire showed remarkable similarities in response patterns among the three groups, with a general tendency to overestimate the incidence and psychological and physical trauma associated with sexual assault rather than to deny these factors.

APPENDIX II-D

IMPORTANT INFORMATION FOR VICTIMS OF SEXUAL ASSAULT

IMPORTANT INFORMATION FOR VICTIMS OF SEXUAL ASSAULT

Prepared by the Sexual Assault Treatment Center, St. Luke's Hospital, Wornall Road at Forty-Fourth, Kansas City, Missouri

Reprinted with permission from the Sexual Assault Treatment Center, St. Luke's Hospital.

WHY SEEK MEDICAL CARE FOLLOWING SEXUAL ASSAULT?

It is important to protect yourself against venereal disease and pregnancy; it is also important that you be examined for any injuries that may be a result of the attack. If you should decide to prosecute the assailant, medical evidence can be obtained only at this time. Personnel in the Emergency Room will encourage you to make a report to the police. However, this is your decision and your wishes will be respected. If you do not wish to report, all medical evidence will be kept at St. Luke's for one week following your examination in the event you change your mind. It will then be destroyed.

WHY REPORT A SEXUAL ASSAULT TO THE POLICE?

All victims of sexual assault are encouraged to report it to the police. The reason for this is that most assailants are guilty of assaulting more than one person. The more information the police department can obtain, the better their chances are of apprehending an assailant. If you report to the police, it does not mean that you have to prosecute. That is a decision that you have a right to make for yourself. Third party reporting is possible. You can give the information about your assailant to the Emergency Room clerk and he or she will give it to the police without using your name. However, you are encouraged to report it to the police yourself. Again, this is your decision.

HOSPITAL PROCEDURE

You will be taken to an examining room as quickly as possible. Someone from the Admitting Office will obtain information from you such as name, address, birth date, etc. Many insurance companies now cover the cost of examination following sexual assault. They also will ask if you have hospitalization insurance. An Emergency Room Physician will examine you for any injuries that may be a result of the sexual assault. The examination will include a pelvic examination which is necessary to secure medical evidence in case you should decide to prosecute the assailant. This examination is done for your protection and benefit.

LABORATORY TESTS

The possibility of pregnancy after a rape is a frequent concern to the patient. Laboratory tests will be administered during the initial examination to determine pregnancy. Positive test results generally indicate that the patient was pregnant prior to the rape; negative test results indicate that should the patient become pregnant, it might be a result of the rape. If the test results are negative, the patient may take one of two steps:

1. Six weeks after the rape, the patient may seek a second pregnancy test. If this test is positive, the patient may opt to terminate pregnancy after consultation with her physician; or

2. At the time of the initial visit the patient can be treated with a drug that tends to eliminate the possibility of pregnancy if given within several hours of the rape. The drug must be taken for a period of five days; a possible side effect of it is nausea.

A member of the Sexual Assault Treatment Center will contact you by phone 24-48 hours after you leave the Emergency Room. She will check on your condition, answer any questions you have, and assist with any problems you are encountering as a result of the assault. The hospital will advise you to be checked again in four to six weeks for the possibility of venereal disease. It is very important that you do this. Agencies which offer this service are [listed].

POLICE PROCEDURE

When you call the police to report that you have been sexually assaulted, a district car will be dispatched to your location. The initial responding officer will ask several questions of you, including your name and address, time, location, statement of the offense and description of the assailant. The district officer then will take you to the Emergency Room of St. Luke's Hospital for a medical examination and medical report. A detective of the Sex Crimes Unit (Missouri) or Crimes Against Persons Unit (Kansas) will meet you at the Emergency Room. If after the medical examination you feel calm enough, you will be taken to Police Headquarters where you will be asked to answer detailed and specific questions regarding the incident. In order to build a strong case, the police must have as much information and evidence as possible. The interview at Police Headquarters can be deferred until the following day, but it is essential to gather the information soon after the incident while the facts are clear in your mind. The case then is turned over to the Prosecutor's Office (Missouri) or the District Attorney's Office (Kansas). At this time, the police determine whether or not there is sufficient evidence for consideration of prosecution. This may be before or after the assailant is brought in for questioning.

COURT PROCEDURE

An Assistant Prosecutor (Missouri) or the District Attorney (Kansas) decides whether or not to prosecute, based on existing evidence. If the evidence is considered sufficient to prosecute, there will then be a preliminary hearing before a judge. This is an informal proceeding of the State Court in which a judge decides whether or not to take the case any further, based on the evidence of the case. The victim is often required to testify at the preliminary hearing. If the judge rules that a crime has indeed been committed and that there is sufficient evidence to warrant a trial, he notifies the defense lawyer and the prosecutor (Missouri) or the District Attorney (Kansas). The trial will be held before a jury.

Several volunteer organizations are empathetic to problems of victims of sexual assault. If you would like to have someone accompany you through all court proceedings you may call: [citizens' action groups listed].

PSYCHOLOGICAL SERVICES

Many times a woman who has been sexually assaulted feels the need to talk about it with someone. This is not unusual or abnormal. You and your family have experienced something very traumatic and may feel frightened, depressed or upset. Many services are available within the city to help you. Please do not hesitate to contact one of the following: [mental health, hospital, family service, neighborhood health and private counseling agencies are listed].

If you have not reported being sexually assaulted, but now would like to talk to a law enforcement officer, you may contact: [relevant police and sheriff's offices are listed].

APPENDIX II-E

FOUR SAMPLES OF HOSPITAL CONSENT FORMS

FOUR SAMPLES OF HOSPITAL CONSENT FORMS

[Used with permission of Mount Sinai Hospital, Minneapolis, and Harborview Medical Center, Seattle.]

CONSENT TO DISCLOSURE OF PRIVILEGED INFORMATION

I, ________________________, hereby request and authorize Mt. Sinai Hospital and its attending physicians to disclose any information which has been acquired as a result of examinations, treatments, or tests upon me to ________________________________. And in consideration of the services furnished to me I release Mt. Sinai Hospital and its attending physicians from any responsibility related to any disclosure of information or to any professional opinions, findings, or recommendations relating to the information as shown in the medical records.

Date ________________________

____
Patient's Signature

Witness ________________________

____
Signature of Parent or Guardian
(if patient is a minor or ward)

Patient's Birthdate __________

____
Signature of Nearest of Kin
(if patient is physically
unable to sign)

MOUNT SINAI HOSPITAL/2215 Park Ave., Minneapolis, Minn. 55404
(612) 339-1681

Final Draft
2/19/73

MOUNT SINAI HOSPITAL
Ambulatory Care Unit

ESTROGEN THERAPY RELEASE

Diethylstibestrol can only be considered as an emergency treatment against pregnancy.

A single one time coitus results in the probability of conception between one in fifty and one in twenty-five.

With treatment of diethylstibestrol, there were no pregnancies in 1,000 cases; this is the basis for our rationale in treatment.

There are side effects of treatment:

1. Headaches, nausea and vomiting are most common.
2. Menstruation may be altered: late, light flow, spotting.
3. There is a slight possibility that pregnancy can occur. As with any drug taken during pregnancy, it can effect the fetus.

Considering the above statements, Mount Sinai or the attending physician will not assume responsibility if pregnancy or side effects do occur.

Signature ______________________

Date ______________________

Witnesses ______________________

____

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HARBORVIEW MEDICAL CENTER
325 - 9th Avenue
Seattle, Washington 98104

CONSENT FOR PHOTOGRAPHY

I, ______________________________, hereby grant permission to be photographed while a patient of Harborview Medical Center. I understand that these photographs will become a part of my medical record.

____
Patient's Signature

____
Hospital Number

____
Parent or Guardian

____
Date

Witness: ________________________

Witness: ________________________

Date: ___________________________

TABLE 4

Name of Patient		Hospital No.	Arrival Date & Hour
Street Address		Phone No.	Age Birthdate
City State Zip		Brought By	
Relative or Friend Through Whom Patient May Be Contacted		Referred By	
Address	Phone No.	Discharge Date & Hour	Discharged to

Authorization for Release of Information

I hereby waive physician/patient relationship of confidentiality and authorize Harborview Medical Center to release copies of all information pertaining to this visit (including all information obtained from my examination and treatment) to: (indicate agency)

Signature and Title of Witness	Patient Signature
Parent or Guardian Signature	Parent of Guardian Address

Medical Report	Time Patient Examined at HMC ☐A.M. ☐P.M.	Date and Time of Alleged Sexual Assault

Psycho-Social History (include emotional state and orientation)

____________imprint below________

Social Worker	Phone No.

University of Washington Hospitals
Harborview Medical Center - S.A.C. Center

History of Sexual Assault
Medical Report &
Authorization for Release of Information

APPENDIX II-F

SUGGESTED PROTOCOL FOR HOSPITAL IMPROVEMENT IN MANAGEMENT OF RAPE VICTIMS

SUGGESTED PROTOCOL FOR HOSPITAL IMPROVEMENT IN MANAGEMENT OF RAPE VICTIMS

By Diane S. Fordney Settlage, M.D.,M.S.

[Reprinted by permission of U.S.C.
Women's Hospital, Los Angeles, California]

I. Phases of Hospital Management:

- A. Arrival to Examination Room
- B. Examination
- C. Release and followup

II. Objectives:

- A. Preservation of the victim's dignity
- B. Obtainment of maximal useful information
- C. Availability of appropriate followup of potential health problems due to the rape episode

III. Assumptions:

- A. Proof or disproof of the alleged rape is a criminal court concern, not a medical concern. Therefore, the basic assumption of medical personnel must always be that the patient is a rape victim.
- B. Only that information bearing directly on medical conditions or the obtainment of medical evidence of the rape and/or possible identification of a potential rapist is appropriately obtained. Elicitation of rape details are unnecessary and potentially traumatic outside the aforementioned areas.
- C. The patient is a victim, not a criminal.
- D. The possibility of further medical management exists and such assistance and information must be offered. Examples: pregnancy, venereal disease, injury management, psychological implications.

IV. Phase I: Arrival to examination

- A. Improvement needed:
  - 1) Elimination of identification of victim as a police problem to other patients and uninvolved clinical and medical personnel.
  - 2) Elimination of waiting time under condition I).
  - 3) Protection of privacy by minimization of involved medical personnel.

B. Specific suggestions:

1) Accompanying police official enter first and alone to state he has a rape victim for examination to one appropriate identified individual.

   a. Involves: police policy
      nursing policy

2) After being informed where the victim should specifically go, the policeman withdraws, relays that information to the victim, and she proceeds alone to that area to be met by the appropriate informed medical person who conducts her to an examination room.

3) Required identification data will be obtained in that room preferably by the same informed individual or by a social service personnel prior to preparation for examination.

   a. Involves nursing (and clerical)

4) Following the identifying data collection, the patient should be prepared for examination by the informed nursing personnel and some advisement of waiting time for the physician made.

   a. nursing policy

V. Phase II: Examination

A. Improvement needed:

1) Appropriateness of conduct of medical personnel to the situation.

2) Completeness of observations and data collection for the purposes of both medical management and possible legal use.

B. Specific suggestions:

1) Special care that inappropriate affect and comment in the immediate presence of the patient and in the nearby environs be avoided.

   a. Involves: nursing and physician policy

2) The police officer be summoned to confirm the identity of the victim and then withdraw to an appropriate area where samples may be given to him directly and privately without the possibility of patient and samples confusion.

3) Historical data as obtained by the physician should include:

   a. Time proceeding the exam that the assault occurred

   b. If bathing or douching occurred after the assault

   c. If penetration occurred, or if he ejaculated elsewhere on her body or clothing.

   d. If pain is present

   e. If non-genital physical trauma occurred

   f. If the victim scratched or injured her assailant

   g. If she is using a birth control method

   h. Age, gravidity, parity and last menstrual period

   i. Information she volunteers spontaneously

4) Examination should include:

   a. General inspection of her entire body with injuries described in detail.

   b. Obtain finger nail sprapings and place in an envelope. Close scrutiny of the clothing, abdomen, mons pubis, and thighs in addition to vulva for:

      1. possible seminal fluid
      2. alien pubic hair
      3. blood

      Hair should be collected in a clean envelope. Possible dried fluids should be collected on saline-soaked swabs and placed in sterile tubes or flaked off into an envelope.

   c. Thorough inspection of vulva, perineal body, anus, introitus and hymeneal ring for injury. Abrasions, erythema, small exoriations or skin separations maybe the only indication of forcible vaginal entry in parous or sexually active women. These should be described in detail.

      1. Photographs of genital and breast injuries should be done by medical personnel to avoid the necessity for later photographs by non-medical personnel.

         a) Involves police policy.

d. Speculum exam with swabs from the cul-de-sac, lateral vaginal wall, vaginal introitus and vulva put on a clean glass slide and allowed to air dry.

e. Additional vaginal secretions (either by swabs sealed in a sterile tube or by medicine dropper contents into a sterile tube) should be taken to allow for police laboratory analysis for alkaline phosphatase and ABO typing on seminal fluid.

f. Cultures for gonorrhea should be taken from the urethra, endocervix and possibly the anus.

g. The remainder of the pelvic examination and medical management should be predicated by findings

5) All samples collected should be placed in sealed envelopes which are labelled with the date, time, place, physician's name, nature of the sample and name of the nursing witness and given to the police officer.

6) The medical record should state all pertinent history, i.e., "patient stated she was raped" and physical findings, as it will be used in court. Incomplete descriptions or opinions can be used to negate the relevance of findings.

7) The microscopic examination and laboratory assessment of all samples should be done by the police pathologist rather than by the physician or hospital laboratory personnel. Police laboratory personnel are legally accepted as experts, hospital personnel may not be.

a. Section 4 - 7 involve primarily the physician and nursing.

IV. Phase III - Release and followup

A. Improvement needed

1) Ability of patient to leave without identification as being in police custody.

2) Information and/or provision of followup for possible consequences of the stated rape.

a. venereal disease
b. pregnancy
c. psychologic trauma

B. Specific suggestions:

1) The police officer leaves the hospital and waiting room area after receiving samples. The patient joins him outside the hospital when dressed.

   a. Involves: nursing and police-policy.

2) The patient should be informed of the G.C. culture and told how to secure the report in 3 to 4 days from the hospital.

   a. Involves: physician and nursing policy

3) She should be instructed in signs and symptoms of both gonorrhea and syphillis and instructed to obtain a V.D.R.L. in six weeks, and her proper course of action with any symptoms.

   a. return to hospital
   b. public health clinic
   c. private physician

      1) involves nursing and physician policy

4) If the woman is midcycle and not using oral or intrauterine device contraception, consideration of high dose immediate estrogen administration, menstrual extraction at the time of next expected menses, or physician appointment at six weeks following the last menstrual period (if she has delayed menses) should be presented.

   a. involves nursing and physician policy

5) All patients should be offered the opportunity for post-rape supportive counseling. Alternatives would be through the hospital psychiatric outpatient counseling service, community counseling services and directed referral to private counselors identified as willing to cooperate.

   a. Involves: physician and nursing policy, liaison with counseling services.

   b. Directed referral should be made to identified individuals to minimize waiting time and referral to areas where problems in services are such that counseling is not realistically or easily available so that the patient is not left to her own resources to find such help.

VII Prepubertal children

A. Identified problems:

1) Children need to be examined by physicians skilled in the gynecologic examination of young children.

2) General anesthesia is often required for adequate examination of the traumatized or frightened child.

3) Parent immediate and short term counseling is required to minimize the psychological effect on the child.

B. Specific suggestions:

1) All prepubertal or young adolescent rape victims should be brought to Women's Hospital rather than the Unit 1 or pediatric pavillion emergency rooms.

  a. Involves police and nursing policy.

2) The child should be examined with a physician familiar with the pediatric gynecology exam (3rd or 4th year resident) and preferably with the full-time staff physician responsible for pediatric gynecology.

  a. Involves nursing and physician policy

3) Historical data must differentiate between fondling, parental suspicion of contact with no evidence of same, and known assault or coital contact. Findings on inspection of external genitalia and the child's reaction will indicate the presence or absence of need for examination under general anesthesia. Any evidence of bleeding from other than a superficial laceration or genital trauma requires general anesthesia for examination, sample collection and surgical repair.

  a. Involves nursing and physician policy

4) Immediate counseling of parents regarding their behavior towards the child is critical.

  a. Involves physician policy

5) Opportunity for parental counseling or parent-child separate counseling should be offered and recommended. Provision for same should be made.

  a. involves physician, nursing and liaison with counseling services policy.

APPENDIX II-G

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS TECHNICAL BULLETIN

[Reprinted by permission of the American College of Obstetricians and Gynecologists.]

ACOG TECHNICAL BULLETIN

NUMBER 14—JULY, 1970
(Revised, April, 1972)
SUSPECTED RAPE

SUSPECTED RAPE

1. PURPOSE

The purpose of this Technical Bulletin is to provide proper procedures for protection of patient and doctor as well as in the interest of justice in cases of alleged or suspected rape or sexual molestation.

2. DEFINITIONS

Rape is coitus without the consent of the woman.

Statutory Rape is coitus with a female below the age of consent. This is usually 16 but differs in the various States or Provinces.

Sexual Molestation is non-coital sexual contact without consent.

3. CONSENT

To protect the physician, written and witnessed consent for the following procedures should be obtained if possible:

a. Examination

b. Collection of specimens

c. Photographs

d. Release of information to proper authorities.

4. CAUTIONS

The physician must protect the interests of the patient, of justice and of himself. Every instance is a potential court case, and the physician should expect to be subpoenaed to justify his statements. Whether rape occurred is a legal matter for court decision and is NOT a medical diagnosis.

Principal cautions are as follows:

a. GET CONSENT

b. GET HISTORY IN PATIENT'S WORDS

c. RECORD EXAMINATION FINDINGS

d. GET LABORATORY WORK

e. SAVE CLOTHING

f. MAKE NO DIAGNOSIS

g. NOTIFY POLICE

h. PROTECT AGAINST DISEASE, PREGNANCY AND PSYCHIC TRAUMA

5. HISTORY

A good history must be obtained and written down as quotations in the patient's words. The time, place and circumstances should be recorded. The patient's emotional state should also be noted (e.g. hysterical, alcoholic, stoic). Has the patient taken a bath since the alleged assault?

6. EXAMINATION

Get consent to examine from responsible person. Is it legal in your jurisdiction to examine the presumed victim before she has been seen by a police surgeon or similar official? Often the evidence needed to establish guilt or innocence in a case of suspected rape has been thoughtlessly destroyed by a well-intentioned physician.

a. General appearance: bruises, lacerations, torn or bloody clothing and condition of patient (e.g. alcoholic, hysterical, punch-drunk) should be recorded.

b. External genitalia: evidence of trauma.

c. Speculum examination: inspect cervix and vagina with a non-lubricated, but water-moistened speculum. Vaginoscope may be useful.

7. LABORATORY SPECIMENS

The following specimens SHOULD be taken:

a. SWAB from vaginal pool, and from any suspicious areas about the vulva. Protect in test tube. These can be examined by police laboratory for:

(1) acid phosphatase

(2) blood group antigen of semen

    (3) precipitin tests against human sperm and blood

b. WET MOUNT of material from fornix examined immediately for motile sperm.

c. Separate SMEARS from vulva.

d. CULTURE for Neisseria in appropriate medium such as Thayer-Martin.

Laboratory specimens should be obtained by a responsible physician in the presence of a witness, and personally handed to the pathologist or technician. They should not be sent to the laboratory by routine messenger service. Unless specimens can be positively identified, the prosecuting attorney may have difficulty in submitting the reports in evidence. Clearly label slides by etching the patient's name on them, using a diamond pencil.

The use of diagnostic tablets will aid in the immediate diagnosis of the presence of acid phosphatase, indicating semen.

8. CLOTHING AND PHOTOGRAPHS

Stained clothing, photographs and any other potential evidence should be retained by the physician and personally turned over to the proper police authorities in return for a detailed receipt.

9. OBJECTIVE STATEMENTS

The record should contain the patient's statements. It should give descriptions of the physician's findings and what he did. It should state to WHOM he delivered specimens, clothing or photographs. The physician should express NO conclusions, opinions or diagnoses to the patient or others. NO conclusions, opinions or diagnoses should be written in the record.

NEVER say or write in the record an opinion concerning whether or not the patient was raped. The phrases "suspected raped" or "alleged rape" may be used when necessary.

The physician should remember that both he and the record may be subpoenaed and that he may be required to testify. All information should be exact and detailed to avoid any misinterpretation. Negative findings are as important as positive ones and may assist in the protection of an alleged assailant who has been falsely accused.

10. CARE OF A CHILD

The protection of a child is an important duty of the physician. Psychosexual trauma must be recognized and minimized. Emotional support and gentle sympathetic understanding of both child and family are very important. The physician must be tactful and kind. The parents should be given reassurance and guidance. They should be warned specifically against magnifying the situation. They should be told to avoid such terms as "ruined," "violated," "dirty," or "lost her innocence" lest the child develop severe guilt feelings and anxiety. It has been shown by many psychiatrists that the child's emotional reaction to sexual molestation is far less damaging than that arising from imposition of adult values upon the episode.

Lacerations should be repaired under general anesthesia. Fine catgut should be used and care taken not to reduce the the size of the introitus. Tetanus toxoid may be indicated inasmuch as these wounds may contain dirt particles and may become infected.

11. PREVENTION OF DISEASE

The attacker may have a venereal disease. For this reason, with the written consent of the family, some physicians customarily give prophylactic antibiotic therapy. In the absence of a penicillin allergy the patient may be given 2.4 million units of benzathine penicillin G (Bicillin®) or an appropriate dose based on age.

12. PREVENTION OF PREGNANCY

The possibility of pregnancy should always be considered. Should exposure occur near midcycle, the administration of large doses of estrogen within 5 days appears to be effective in preventing implantation.

Widest experience has been with diethylstilbestrol 25 mg twice daily, or 50 mg of stilbestrol diphosphate (Stilphosterol®) once daily, for 5 days. Success has also been reported with ethinyl estradiol 5 mg daily for 5 days. The only significant side effect appears to be nausea which occurs in approximately half the patients. This can be lessened with concomitant prochlorperazine (Compazine®) 15 mg spansules once or twice a day.

(continued on back page)

To assist in obtaining the necessary authorizations and data a standardized form is of great value. On the page opposite is a suggested SUSPECTED RAPE form. It may be reproduced or adapted.

MEDICAL REPORT Suspected Rape	_______________ (Hospital Name) Receiving Ward	Date Brought by:
Name of Patient		Birthdate
Address		Age

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize ______________________ (Hospital Name) to supply copies of ALL medical reports including any laboratory reports, immediately upon completion, to the Police Dept. and the Office of the District Attorney having jurisdiction.

Person Examined______________________

Address______________________

Date______________________

Parent or Guardian______________________

Witness______________________

Address______________________

MEDICAL REPORT	Time arrived	Date & Time of Alleged Rape
History (as related to physician)		
EXAMINATION	Date	Time
General Examination (include ALL signs of external evidence of trauma)		

Laboratory Specimens Collected ☐ Yes ☐ No (Mandatory, or explain absence)	**Pelvic Examination** (include ALL signs of trauma, size, and development of female sex organs)
Date__________ Time__________	Vulva
Smears _____Vulva	Hymen
_____Vagina	Vagina
_____Cervix	Cervix
Saline Washings _____Vulva	Fundus
_____Vagina	Adnexa (right)
	Adnexa (left)
	Rectal
(Laboratory Reports Attached)	Examining Physician

I hereby certify that this is a true and correct copy of the official______________________ (Hospital Name)
Records concerning the examination of the above named patient.

Date

Title

12. Prevention of Pregnancy (Contd.)

Less nausea is encountered if intravenous Premarin® 25 mg a day for 3 days is used, but experience with this method is considerably less than with stilbestrol.

As estrogens are more properly post-ovulatory than post-coital contraceptives, patients should be carefully questioned about prior exposures in the cycle and warned to avoid subsequent unprotected exposures in the same cycle. A basal temperature chart may be useful in determining whether the patient has ovulated. Temperature will usually decline while on estrogen. If the patient does not have a period within 3-4 weeks of treatment, a D&C should be done.

If a pregnancy occurs as a result of rape, its interruption is indicated.

13. FOLLOW-UP OF PATIENT

All patients should be followed to be certain that they do not develop a venereal disease, or become pregnant. The possibility of delayed psychologic effects on child and parents must be remembered. The family physician or a trusted pediatrician is best suited for patient follow-up. In an institutional milieu, one physician should accept the responsibility for supervision and guidance.

14. LOCAL LAWS AND REGULATIONS

The physician must familiarize himself with local laws, regulations and customs. The requirements for police notification vary. If the patient alleges rape, there is usually a duty to report immediately. If rape is suspected, but not stated, "an authorization for release of information" should be obtained.

In some states a physician may not examine a patient until she has been examined by a police surgeon or other authorized medical personnel.

If the child is less than 18 years of age there may be a duty to make an immediate verbal report to designated officials under the "battered child laws."

This Technical Bulletin is prepared (with consultation from appropriate experts) by the Committee on Technical Bulletins of The American College of Obstetricians and Gynecologists. It describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of The American College of Obstetricians and Gynecologists. Its publication should not be construed as excluding other acceptable methods of handling similar problems.

THE AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS
One East Wacker Drive Chicago, Illinois 60601

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APPENDIX II-H

FOLLOW-UP FORM

FOLLOW-UP FORM

[Reprinted by permission of Sexual Assault Center, Harborview Medical Center, Seattle, Washington.]

INSTRUCTIO[illegible]ET FOR ______________________________

An appointment has been made for you in ____________ Clinic.

On ________________ at ________________.

It is important that you keep this appointment for follow-up care. Please call the number below if you have any problems before your appointment.

Please do call the number for an appointment change or advice, if you feel the need, especially if you experience:

1. Emotional distress, or need help with the social or legal problems arising from this incident.
2. Signs of infection such as fever, pain, sores, discharge, etc.
3. Urinary symptoms such as frequent urination, pain on urination or difficulty urinating.
4. Unusual vaginal bleeding.
5. If your menstrual period does not occur when expected, either normally or after hormonal therapy, if given to you. (This should occur within seven (7) days after stopping the medicine).
6. Venereal disease tests have been done. Results are available at the number below. (No sooner than four days). These tests should be repeated in two months. You have been given a laboratory request slip which may be taken to the Laboratory on the second floor.
7. If you have any questions about the instructions given to you.

NUMBER TO CALL:	223-3047	8:30 - 5:00 Monday-Friday
	223-3074	Emergency Room (as for social worker)

AS FOR: ______________________________

Sexual Assault Center, Harborview Medical Center

APPENDIX IV-A

ISSUES INVOLVED IN CHANGES OF LAWS RELATED TO RAPE

ISSUES INVOLVED IN CHANGES OF LAWS RELATED TO RAPE

During the past several years, a rapidly growing number of states have reviewed proposals to amend their criminal codes to change the law governing rape. The revisions considered range in comprehensiveness from merely making rape a nonprobational offense in Ohio to acceptance in Michigan of a complete restructuring of the definition of criminal sexual conduct, the penalties provided, and the evidentiary standards used. The two major areas of reform have been the redefinition of the crime and the revision of the rules of evidence governing rape trials.

At least three states–California, Massachusetts, and Michigan–have legislatively mandated improved treatment of rape victims by the criminal justice system and the provision of social services to victims. At the federal level, Congress has voted to establish a Center for the Prevention and Control of Rape, but the President has not yet approved the measure.

The major issues involved in all of these kinds of legislation are outlined in this material, and examples are given of states that have acted on the issues. The final section lists groups making comprehensive studies of the rape laws in all the states and individuals or organizations who have been active in rape law reform and who would be appropriate resource persons.

Definition of the Crime

A number of states, including Florida, Massachusetts, Michigan, and Nebraska, have adopted major revisions of the definition of rape. In these four, the crime has been redefined to apply to both sexes, to include oral and anal sexual contact, to create degrees of criminal conduct not requiring penetration, and to provide that the threat of force or coercion is sufficient to establish coercion rather than requiring personal injury in all cases. All, except Massachusetts, permit such threats to be against a third person. A fifth state, Texas, allows the woman to submit under "reasonable fear" that she would be injured. Michigan also has a provision allowing a spouse to bring sexual assault charges against the other legal spouse if the two are living apart and one has filed for separate maintenance or divorce. Minnesota excludes from protection of the law a woman who is living with her assailant although not married.

The most innovative reform in this area is the categorizing of the crime into varying degrees of sexual offenses. This has been done in Florida, Michigan, and Minnesota. Florida classifies as a life felony sexual battery of a person 11 years old or younger and sexual battery of a person over 11 without that person's consent and using or threatening to use a deadly weapon or physical force likely to cause serious personal injury. A first degree felony is sexual battery without consent and under one of the following circumstances: the victim is physically helpless to resist the threat of force; violence or retaliation is used; the offender has administered some substance to incapacitate the victim; the victim is between the ages of 11 and 18 and the offender is in some position of authority over him or her; or the offender has knowledge that the victim is mentally defective. Sexual battery of a person over 11 without consent and using force not likely to cause serious personal injury is a felony in the second degree.

The Michigan statute establishes four degrees of criminal sexual conduct. The first degree entails sexual penetration under any of these circumstances: the victim is under 13, the victim is between 13 and 16 and the actor is in a position of authority over him or her, the actor committed another felony at the same time, the actor was aided and abetted and the victim was mentally or physically impaired or the actor used force or coercion, the actor had a weapon, or the actor caused personal injury to the victim and the actor used force or coercion or had knowledge that the victim was mentally or physically impaired. Criminal sexual conduct in the second degree is sexual contact (without penetration) plus one of the same circumstances set out for the first degree crime. Third degree criminal sexual conduct includes penetration and one of the following: the victim is at least 13 but under 16, force or coercion was used, or the actor had knowledge of the victim's mental or physical incapacities. The fourth degree entails sexual contact plus force or coercion or knowledge of the victim's incapacities. Michigan also criminalizes assault with intent to commit criminal sexual conduct. Note that this statute makes sexual penetration or contact with a child under 13 a first and second degree offense; sexual penetration of a child between 13 and 16 is a third degree offense unless the actor has authority over the child, in which case it is in the first degree category.

An advantage of this type of degree structure is that it should help to secure conviction in sexual assaults where the victim is not seriously injured, a situation previously ignored by many in law enforcement and prosecution. A further advantage is that penetration is not required for some degrees of criminal sexual conduct. This recognition that sexual abuse other than penetration can be equally damaging is most clearly illustrated by the criminalization of "sexual contact" by Michigan. "Sexual contact" is defined to include the intentional touching of the person's intimate parts or the clothing covering such areas, if the touching can be construed as being for the purpose of sexual arousal or gratification. Minnesota has enacted a degree structure much like Michigan's.

The National Organization for Women Task Force on Rape proposes to define rape as an act of sexual intercourse including oral and anal sodomy and penetration by a device, accomplished by coerced bodily contact between two persons of either sex where the person is forced to submit, physically or mentally unable to resist or incapable of giving legal consent, or threatened personally or to a third person. The National Organization for Women would also criminalize assault with intent to commit rape and set the age for statutory rape as under 12.

Penalties

Proponents of rape reform contend that the severe penalties mandatory in many states deter judges and juries from convicting accused rapists. They recommend a general lowering of penalties to fit the severity of the crime.

At least four of the states that have enacted or are considering changes in their punishment for rape seem to be following this suggestion. The Massachusetts statute would permit a life sentence for rape or assault with intent to commit rape and Michigan would allot it for criminal sexual conduct in the first degree; however, it is not mandatory in either state. Massachusetts and Michigan also provide stricter punishment for second offenders. Nebraska's new law provides for one to 24 years for sexual assault in the first degree. Minnesota's maximum penalty is 20 years for conviction of aggravated sexual assault in the first degree. There is a mandatory three-year sentence, without parole, except when the offender completes a treatment program.

The National Organization for Women recommends the elimination of the life imprisonment penalty except in cases where the victim met with death, permanent bodily injury, or permanent mental impairment and in case of conviction for the third offense. The National Organization for Women also suggests that parole be granted only after the rapist has served one year for the first offense and five years for the second offense, with intensive rehabilitative counseling. In the absence of such counseling, the National Organization for Women believes a term of not less than four years should be served before parole is granted. The task force would further limit parole to those cases in which the state can guarantee that repetition of the offense would be highly improbable, if not impossible.

Evidence

A primary concern of reformists is to eliminate the need for evidence corroborating the testimony of the victim. The statutes recently enacted in Florida, Iowa, and Michigan specifically state the victim's testimony need not be corroborated. Minnesota has eliminated such a need in prosecutions for aggravated sexual assault or for sex with a child, while Texas does not require corroboration if the victim makes "immediate outcry." This requirement is considered to have been met if the victim tells another person about the rape within six months of the date it took place. These reforms leave only five jurisdictions in which the law requires corroboration: Georgia, Idaho, Nebraska, the District of Columbia, and the Virgin Islands. In a recent revision of its rape law, the Nebraska legislature failed to change the corroboration requirement on the grounds that the judiciary is interpreting the requirement reasonably.

The second major evidentiary reform is of the rules governing the admissibility of evidence of the victim's prior sexual conduct. Nebraska, California, Iowa, Michigan, Minnesota, and Texas have recently acted in this area. All of them require a request to the court to hear evidence in the judge's chambers and to determine whether or not the evidence should be heard by the jury. However, each state has different standards for its courts to apply in deciding whether to admit the evidence into the record. Iowa and Texas admit evidence of any such conduct if it is relevant and occurred no more than one year before the alleged crime. The one-year limitation does not apply to evidence of conduct of the victim with the accused.

Michigan and Minnesota admit evidence of specific instances of sexual activity to show the source of origin of semen, pregnancy, or disease. They also admit evidence of the victim's past sexual conduct with the accused, but only if the judge finds that the evidence is material to a fact at issue in the case and that its inflammatory or prejudicial nature does not outweigh its evidentiary value. Minnesota follows this pattern, but also admits evidence of sexual activity with different persons if it is relevant to show a pattern of promiscuity. Minnesota applies these evidentiary rules only to cases of aggravated sexual assault or sex with a child.

In Iowa and Nebraska, the standard for judging evidence of the victim's prior sexual conduct with anyone is whether it is relevant to the issue of consent. California, on the other hand, considers only evidence of conduct with the accused relevant to consent. The California statute admits evidence of the victim's prior sexual conduct with persons other than the accused only if it is relevant to attack the credibility of the victim.

This particular reform has been one of the most hotly debated issues. Opposition to it is based on the belief that evidence of previous sexual activity is relevant to the question of whether the victim actually consented to the alleged rape. The fear is that the new legislation will deny the accused the opportunity to defend himself by showing facts that he believes establish consent. Proponents of the reform claim this fear is unwarranted, because all the new statutes admit evidence that shows the circumstances surrounding the alleged rape and the relationship between the accused and the victim.

The National Organization for Women Task Force would be even more restrictive. It would admit no evidence of the victim's prior sexual conduct with persons other than the accused and would allow evidence of sexual activity with the accused to be admitted only to the extent that it is determined by the court *in camera* to be relevant. Emphasizing that a victim's previous want of "chastity" is irrelevant in determining consent at the time of the alleged assault, they recommend that consent be determined solely from the victim's testimony about his or her conduct at the time of the assault. The National Organization for Women would also admit evidence of the accused's history of sexual offenses and testimony of previous victims of the accused. Iowa and Texas concur in this view only to the extent of allowing evidence of prior felony convictions to impeach credibility. Under Nebraska's new law, and in Texas, the defendent's past sexual conduct, as well as the victim's, may be admitted if the judge determines it is relevant.

Privacy

Several of the new bills have special provisions protecting the privacy of the parties involved in a rape prosecution. The Florida statute makes it a misdemeanor to print, publish, or broadcast the name or address of any victim of any sexual offense. The validity of this law is in question, however, in light of the Supreme Court's recent decision in *Cox Broadcasting Corp. v. Cohn*, 95 S.Ct. 1029 (1975). In that case the Court said that a state cannot prohibit publication of information that is on the public record.

In Michigan and Minnesota, upon request of a party, the names and details of the alleged offense can be suppressed until the accused is arraigned or the charges dismissed. A victim in Texas may request that the judge at his or her discretion exclude the public from the courtroom during her testimony. The argument for these provisions is the need to end the humiliating treatment often afforded rape victims which discourages victims from reporting the crime to the officials.

Jury Instructions

The California legislation specifically prohibits any instruction to the jury from which it may be inferred that a woman who has previously consented to sexual intercourse with persons other than the accused is more likely than not to have consented with the accused. Also forbidden is any suggestion that the sex of the witness should be considered in determining the credibility of that witness. Finally, the term "unchaste character" is never to be used in jury instructions in a rape case. The National Organization for Women proposal echos this plea to view the victim's testimony no differently from that of any other witness.

Other Trial Related Reforms

The National Organization for Women Task Force suggests several other provisions yet to be enacted by any state. These include a minimum bail of $25,000, the elimination of plea bargaining in rape cases, no dismissal of the charges without the complainant's consent, the right of the victim to be represented in court by counsel, and no continuances except for emergencies.

Mandatory Upgrading of Police Response to Rape

Massachusetts now requires units in all police departments to improve the reporting and prosecution of rape cases. They must employ specially trained police officers (especially women officers) and maintain a 24-hour telephone line for reporting rape. The New Jersey legislature is considering a bill to establish county central crime analysis units.

The most comprehensive reforms in this area have been called for by the California legislature. However, because this was done in the form of a resolution rather than a statute, the required changes have not been enforced. They include the establishment of special rape investigation units and the training of officers to staff them, special police training with emphasis on the psychological and emotional effects of sex crimes on the victims, placing policewomen in positions to respond to rape reports, thorough examinations of rape victims for physical and emotional trauma and referral to available resources, the costs of the examination to gather evidence of rape not to be charged to the victim, and school districts to offer physical education classes for pupils in nonaggressive self-defense.

The National Organization for Women Task Force would expand these services even further to include the right of the victim to have a friend present at all stages of the investigation and trial, the right to free treatment for VD and pregnancy (including abortion), medical treatment at hospital emergency rooms without police notification if the victim so desires, and the right of the victim to request that a policewoman question him or her.

Center for the Prevention and Control of Rape

Congress is considering a bill to establish a national center to be funded through the National Institute of Mental Health. This measure, sponsored by Senator Charles Mathias (R. Md.), was passed as an amendment to the Health Services Act. The act, just reported out of conference committee with the rape proposal intact, must now be approved by both the House and the Senate and sent to the President. A similar bill was vetoed by the President in early 1975.

The bill would establish a research and demonstration program to explore the causes, consequences, prevention, treatment, and control of rape. The center would investigate:

- The effectiveness of existing Federal, state, and local laws dealing with rape.
- The relationship, if any, between traditional legal and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape.
- The treatment of the victims of rape by law enforcement agencies, hospitals or other medical institutions, prosecutors, and the courts.
- The causes of rape, identifying to the degree possible social conditions that encourage sexual attacks, motivations of offenders, and the impact of the offense on the victim and the family of the victim.
- Sexual assaults in correctional institutions.
- The actual incidence of forcible rape as compared to the reported cases and the reasons for not reporting rapes.
- The effectiveness of existing education and counseling programs designed to prevent and control rape.

It would be the duty of the center to report to Congress annually, through the Secretary of Health, Education and Welfare (HEW), on the progress of this study and research and demonstration projects, and to make recommendations where appropriate. The center would develop and maintain a clearinghouse for information on the prevention and control of rape, the treatment and counseling of the victims of rape and their families, and the rehabilitation of offenders. The center would also compile and publish training materials for personnel who are engaged or intend to engage in programs designed to prevent and control rape.

In addition, the center would make grants to community mental health centers, nonprofit private organizations, and public agencies to conduct research and demonstration projects concerning the control and prevention of rape. Projects funded would include but not be limited to alternative methods of planning, developing, implementing, and evaluating programs used in the prevention and control of rape, the treatment and counseling of victims of rape and their families, and the rehabilitation of offenders.

Resource Persons and Organizations

Several organizations have recently made comprehensive studies of state rape laws. A compilation of the legislation and relevant case law of every state prefaced by a historical analysis of rape law has been prepared under a grant from the National Institute of Law Enforcement and Criminal Justice of the Law Enforcement Assistance Administration (LEAA). It will soon be available from the National Legal Data Center, P.O. Box 1012, 60 West Olsen Road, Thousand Oaks, California 91360, phone (805) 492-2453.

Another study has been done by the Center for Rape Concern at Philadelphia General Hospital, which is funded by the National Institute for Mental Health (NIMH). This center has reviewed rape statutes in all 50 states and will be issuing a report later in 1975. The publication will include model statutes.

Another source of information about the status of rape laws around the country is Lynn

Olson, Criminal Justice Project, National League of Cities, 1620 I Street, N.W., Washington, D.C. 20006, phone (202) 293-2945.

Citizen action or government groups needing information and advice on drafting and supporting legislation may wish to consult persons who have been involved with similar issues in a different state. The following individuals have published or do public speaking with regard to rape law and have been associated with efforts to reform the law in their states.

Professor Barbara Babcock
Stanford University Law School
Palo Alto, California 92605

Jan BenDor
Office of the Prosecuting Attorney
1200 Frank Murphy Hall of Justice
1441 St. Antoine Street
Detroit, Michigan 48226

Kathy Bonner
Texas Rape Prevention and Control Project
P.O. Box 13072, Capitol Station
Austin, Texas 78711

Mary Ann Largen
c/o NOW Legislative Office
1107 National Press Building
Washington, D.C. 20004

Professor Cybil Landau
Hofstra University Law School
Hempstead, New York 01550

Camille LeGrand
c/o Blair and LeGrand
1095 Market Street, 4th Floor
San Francisco, California 94102

Carol Murray
1753 Kilbourne Street, N.W.
Washington, D.C. 20010

Professor Virginia Nordby
University of Michigan Law School
Ann Arbor, Michigan 48104

APPENDIX IV-B

EVALUATION

EVALUATION

A. Evaluation: What and Why

1. *What Evaluation is.* Evaluation is the process of getting answers to the questions of what works or doesn't work about a program, and why. In the context of this handbook, it is the process of measuring the effectiveness of a program treating victims of sexual assault against the goals that the program has set for itself.

It is common to think of evaluation as an extremely technical process—usually required by a funding source—that renders up a mathematically precise verdict at the end of a program as to whether it should be continued. But, the process need not be that complex in order to serve a practical purpose for the program. Evaluation can also be viewed as a process of taking stock: gathering statistics and other data about a project, looking at the data in the light of the values or goals that the project embodies, and then making an *informed judgment* about whether the program (or a certain aspect of it) is in fact effective and how it could be improved.

2. *Benefits of conducting an evaluation.* Most, if not all, program administrators are continuously involved in an informal process of evaluating what they and their staff members are doing. A formal evaluation, however, is important because administrators can miss—or fail to act on—information of genuine value if it is gathered casually. There are many advantages to a structured assessment throughout the life of a program. The following are examples of the importance of formal evaluation.

a. *Administration.* Evaluation is an administrative tool. When it is combined with planning in a continuous and cyclical process, it allows an administrator to design a program targeted toward certain goals, to outline steps for meeting those goals, to measure progress, and to pinpoint weak areas needing correction.

b. *Service delivery.* Evaluation information can help ~~develop better~~ services for rape victims—service that is more sensitive, innovative, directed toward client needs, and closely and productively coordinated with services of other helping agencies.

c. *Funding concerns.* Funds for social programs—whether from public or private sources—are becoming increasingly limited. The result is intense competition. Programs that can demonstrate and document both effectiveness and continued patterns of improvement and growth are in much stronger funding positions than those that cannot. Most funding sources now require proof of a structured evaluation design.

d. *Policy development.* Adequate evaluations not only help shape and reshape specific programs, they also make possible policy development that sets a framework for subsequent and related program effort. This may be policy affecting one local organization or programs (an internal policy), or there can be a cumulative effect, with judgments based on evaluation of several programs helping to shape policy for an entire agency or group of related programs.

3. *Typical findings from an evaluation.* As has already been implied, evaluation is not a process that comes into play only at the end of the life of a funded program. The following examples indicate some of the kinds of questions and findings that might typically emerge from evaluation of rape victim treatment programs instituted by citizen action programs.

Area: *Improvement of existing services*

Typical findings: Finding the weak or missing links in a program designed to provide continuing support for a victim throughout the system—from hospital to trial.

Whether a hotline is underutilized because of lack of publicity or because of other reasons.

Area: *Development of new services*

Typical findings: Whether a coordinated treatment program, jointly sponsored by several community agencies, needs to add long-term counseling capability.

Whether there is strong need to open a rape information hotline at police headquarters.

Area: *Determining cost-effectiveness of services*

Typical findings: whether the extra cost of training and keeping on 24-hour duty personnel to cover a hotline is justified by the volume of clients.

Whether a public education program can be self-supporting through speaking fees and publications sales, or must seek outside funding.

Area: *Adequacy of program performance, in relation to need*

Typical findings: Whether program "X"–though excellent in its treatment of rape victims–is too inaccessible to serve the majority of victims with maximum effectiveness.

Whether a rape crisis center, given a static level of staff and telephone capacity, can handle an increased volume of clients if its existence is publicized in a citywide media campaign.

Area: *Recognizing the needs of all involved parties*

Typical findings: Whether the hospital procedures for completion of rape protocol sheets and maintenance of records meet the forensic needs of the police.

Whether an otherwise adequate court program "fails" because it requires an unreasonable number of court appearances by busy medical personnel.

Area: *Soundness of theory or approach*

Typical findings: Whether citizen initiated crisis intervention programs are more readily accepted by rape victims and their families than those run by public agencies.

Whether women counselors are more likely than men to ease victim trauma.

4. *Who evaluates.* There are basically three ways to get an evaluation done: self-evaluation, outside evaluation, and control agency evaluation.

It is quite possible to have the evaluation done by the project staff members themselves. This is usually called self-evaluation or self-assessment. Self-evaluation refers to the process by which a program measures its own performance against what it construes to be its goals and objectives. This process translates into asking and answering the question: "Given what we are trying to do in the community, are we doing a good job?" The possible problem in self-evaluation is that personal investment in the program may limit objectivity, discussion of staff performance, and complete reporting.

The second approach, outside evaluation, involves calling in an individual or team to conduct the evaluation. In many cases, outside evaluation measures the project's effectiveness against some predetermined goals, objectives, and accomplishment standards for projects of this type. It is often done from a wider perspective based on academic standards of measurement rather than self-assessment.

A third possibility may exist for some local programs attached to large community service organizations or to a state or federal agency. Evaluation can be done by a planning and evaluation unit within the larger institution sponsoring the program. In this case, the project would probably be evaluated from the perspective of the larger institution's goals and objectives.

While each of these is appropriate in certain situations, and each is frequently used, it is the assumption of this manual that self-evaluation or self-assessment will be the most practical, feasible, and frequently employed method for local projects.

5. *What evaluation does not provide.* Even a good evaluation cannot give administrators the

final word on whether a program should be continued, or how it should be improved or adapted, or cut back or enlarged. Basically, any evaluative decision is based on many factors—only one of which is program effectiveness. Carol Weiss has summed up the limitations of evaluation well:

> Evaluative facts have an impact on collective decisions only to the extent that program effectiveness is perceived as valuable. And program effectiveness—inevitably and justifiably—competes for influence on decisions with considerations of acceptability, feasibility, and ideology. Sometimes it is emotionally and politically rewarding to run a program even when it has been shown to have little effect if the alternative is to do nothing for a particular group. Sometimes the existing ideological climate precludes the adoption of more effective programs if these violate cherished assumptions and values. (Weiss, Carol H., *Evaluation Research: Methods for Assessing Program Effectiveness.* Englewood Cliffs, New Jersey: Prentice-Hall, Inc. 1972 [p. 4])

6. *In conclusion.* Evaluation is a continuous process of judging performance against expectations. Done properly, it helps program personnel make decisions about the most sensitive and effective use of their resources. It is not an exact science, because evaluation is not a process that can deliver up a yes/no decision that removes the need for judgment. Evaluation is, however, a process that should function independently of the evaluator's perspective.

B. An Approach to Evaluation

It is not possible, in a handbook of this scope and nature to give step-by-step rules or guidelines for conducting an evaluation. But, a basic approach or way of thinking that characterizes all evaluation efforts can be described in brief. Further study of the subject is essential; a bibliography is included at the end of this appendix.

1. *Five basic questions.* Evaluation involves the posing and answering of five questions:

- What area of the project is the *focus* of the evaluation?
- From what *perspective* is the evaluation to be conducted?
- What are the *goals* of the program or program aspect to be evaluated?
- What *information* will be needed to measure progress toward these goals?
- *How* can the information identified as necessary be gathered?

Some elaboration on these questions may be in order.

a. *Focus.* Evaluation does not have to take into account the total program. An organization may want to evaluate just its outreach program, or its internal management, or the cost-effectiveness of a particular training project. Any evaluation should start with a careful definition of just what the focus is to be.

b. *Perspective.* Just as focus can be limited in an evaluation, perspective can also be limited. An assessment of a rape victim treatment program connected with a prosecutor's office, for example, could come out with rather different findings and recommendations on the effectiveness of the program if the perspective were shifted from that of rape victims to that of personnel from other agencies involved in the program or to that of the general public. In a training program for counselors of rape victims, a training effort that was too costly of an agency's resources—and thus unsatisfactory for that agency—might still be highly rated by both the trainees and the recipients of the counseling services. The results depend on whether the perspective is from the agency, financial, or victim point of view.

c. *Goal setting.* Program goals are critical ingredients of any evaluation process. Goals are the desired ends toward which program is directed and progress measured.

Most programs, of course, have general purpose goals before evaluation. These goals may be very broad—"to meet better the needs of rape victims," for example, or "to make the police department more sensitive to complainants in rape cases." Broad goals like these, without further specificity, are difficult for both program staff and the would-be evaluator to work with. As a result, some goal setting or goal refinement almost always falls to the evaluator.

It may be helpful to think of this goal setting as a multi-step process. The project begins with a broad or overall goal for a program. The next step is to define a number of lesser goals or objectives which will measure areas in which the overall goal has been met. A goal of a citizen action program might be to "educate the community with respect to the crime, its impact on women, and the need for institutional reform." Some objectives might be:

- To set up a speakers' bureau.
- To prepare a brochure and disseminate it to high schools, colleges, and women's groups
- To investigate and prepare a report on emergency room procedures at the local hospital.

After having listed goals and objectives, the evaluator needs to determine how to express them in as precise and measurable terms as possible. For example, it would be easier to define progress toward the objective of setting up a speakers' bureau if the actual objectives were to "set up a speakers' bureau of at least 15 persons qualified to speak in a minimum of four subject areas: legal reform, rape prevention, victim services, and changing the institutions." Where goals are "soft" or difficult to quantify, it is important for the evaluator to define them with as much specificity as possible.

d. *Information needed.* Sound evaluation is based on information gathered over the duration of the project or program to be evaluated, rather than information gathered, retrieved, or restored at the end of the project. So, it is important to plan from the outset what kinds of information will be gathered, and, especially, to think through how you can get information that measures progress toward goals that cannot be quantified.

To measure progress on the objective of speeding up the time between incident and disposition of case, the information needed is the records showing average duration between incident and disposition before the new program started, and then during the new program. For the objective about coordinating more effectively with hospital and police, the information may be more diverse and include such things as the number of contacts between officials of the agencies involved, the presence of interagency councils or committees, and the stated attitudes of personnel involved.

e. *Method of gathering.* There are a number of ways to get information for evaluation. The standard methods include maintaining and monitoring office records; conducting interviews with project personnel, clients, and others; using questionnaires or surveys; and drawing from the observations of those conducting the evaluation.

2. *Putting it together: The evaluation design.* Evaluation works best when it proceeds on the basis of a plan or design. Only in this way can accomplishments be systematically and consistently measured. This plan or design, committed to paper, is called the evaluation instrument. The instrument can be simple or complex, depending on the nature of the evaluation and on the resources and experience of the organization involved. It would be expected, for example, that a citizen action program staffed largely by volunteers would opt for a much simpler evaluation than would a police or prosecutor program accustomed to evaluation and, perhaps, supported by public funding programs that require evaluation of special projects.

A simple instrument, based on the example of the citizen action program that has been referred to in the previous pages and used to evaluate progress toward just two project objectives, is shown in Illustration I. A design of this type could be expanded to cover a much more comprehensive evaluation or self-evaluation if all objectives of the major program goals were treated in the same fashion as the samples.

For more sophisticated evaluations—those which might involve exclusion of variables, establishment of control groups, and other techniques—the reader is referred to the bibliography.

ILLUSTRATION I

GOAL: To educate the community with respect to the crime of rape, its impact on women, and the need for institutional reform

Objective	Expected results of activities undertaken to meet objectives	Information needed to measure	How gather
To set up a speakers' bureau	• Availability of rape crisis center services will be known in segments of the community where speeches are given	• Demographic data on persons writing or telephoning the crisis center	• Examine office records
	• Increased number of volunteers from segments of community where speeches are given	• Demographic data on volunteers	• Examine office records
To prepare and disseminate a brochure to high schools, colleges, and women's groups	• Increased number of users of rape crisis center from target groups of readers	• Information on whether rape crisis center users have read the brochure	• Query users of rape crisis center
	• Involvement of community and school groups in rape reduction activities	• Listing of all groups in the community involved in rape issue	• Telephone survey of community groups

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APPENDIX IV-C

SOCIAL, PSYCHOLOGICAL ASPECTS OF RAPE

SOCIAL, PSYCHOLOGICAL ASPECTS OF RAPE

A. The Crisis of Sexual Assault

Sexual assault is a life-threatening situation in which a woman is abused in a violent manner; her life and her body are involuntarily in the hands of a hostile man. Like other life crises, rape is an experience that disrupts the victim's psychic equilibrium. Her ability to cope or function may be seriously compromised momentarily or for an undetermined length of time. However, certain aspects of the rape situation differentiate it from other situational life crises.

Rape is a specific act of violence perpetuated against a female, incorporating elements of forced sexual behavior, surprise, and invasion of innermost physical and psychic privacy. It is a highly personalized crime. Legal components of the definition of the crime–requiring proof of force, penetration, and assailant identity–place tremendous subsequent pressure on the victim, for she may not be believed when she reports a rape. Society's ambivalent attitudes toward the role of the victim in the crime of rape may also contribute to a victim's personal feelings of self-blame, fear, and shame.

Historically, rape laws were probably formulated to protect women as man's property; to rape a man's wife or daughter was to injure the man himself. Anthropologists have also suggested that some limits had to be placed on indiscriminate intercourse, thus channeling sexuality into marriage and perpetuating that institution. Basically, society does not want to believe such a crime has been committed. Juries routinely acquit rapists to encourage the acceptance of that belief. These attitudes affect the way a victim is treated at the time of crisis, and bear heavily on her subsequent adjustment to the assault.

Some concepts relating to stress reactions are particularly applicable to sexual assault. Weiss and Payson[2], using concepts from Tyhurst[3], stated:

> Stress reactions are attempts to defend or restitute the personality . . . from disorganization. Stress reactions can break down preexisting healthy adjustments and patterns of behavior, or they may enable the individual to advance to a healthier level of adaptation . . . Successful or unsuccessful reactions to stress are dependent on personality development and social structure. One cannot predict with certainty a specific reaction of any individual . . . unless a great deal is known about the predisposing personality and the immediate social organization. . . . The reaction to stress also depends on the age and physiological integrity of the individual.

They describe four overlapping phases of stress reaction: (1) the anticipatory phase, (2) the impact phase, (3) the recoil phase, and (4) the post-traumatic phase. These phases are applicable to all crises, as well as rape.

1. *The anticipatory phase* is particularly relevant to rape. Griffin[4] has stated that most women are "never free from the fear of rape." Yet most women also assume an illusion of invulnerability, which has its useful function of protecting the individual from limiting her life or living in constant fear. However, according to Weiss, a certain amount of "worry work" or assessment of a threat or danger makes a woman aware of the efforts, strengths, and alliances she can muster in case of danger. Thus, exposure to rape education can reduce excess denial or unawareness of the danger that daily exists for many women. If an assault occurs, this preliminary "worry work" can contribute to a successful psychological adjustment. This anticipatory behavior is experienced in situations such as civil

defense rehearsals, wearing seat belts, first aid training, and self-defense training.

2. *The impact phase*, immediately after the rape, may be manifested in varying degrees of personality disorganization. Fox and Scherl[5], and Burgess and Holmstrom[6] describe victim feelings of shock and disbelief, followed by fear, anger, and anxiety. Expressed behavior may include sobbing, tenseness, agitation, decreased alertness, narrowed attention span, and lack of affect and awareness of surroundings. Behavior may become automatic and conditioned by learned behavior that an individual has used in other crisis situations. During this immediate stress phase, effective guidance directing the individual into purposeful activity will help her adapt, reduce her anxiety, and restore feelings of self-control. There are many tasks that need to be performed at this time, and the victim's participation in contacting people, making decisions about treatment, and reassuming family responsibilities will help reactivate her and give the counselor an indication of the victim's inner and external resources.

Also, during the impact phase, insensitive, accusatory, and nonsupportive attitudes from family, friends, and institutional personnel will exacerbate the victim's emotional stress. Consequently, rape victims may display more complex and longer lasting personality disorganization than expected.

3. In the *recoil phase*, the victim may display an outward adjustment as she begins to resume emotional expression, self-awareness, and behavioral controls. Physiological reactions seen earlier, such as loss of appetite and sleep, muscular tension, and physical trauma associated with the rape, will diminish. The victim will resume her normal activities, and her learned psychological defenses will come into play. She will tend to deny her feelings about the rape and put her energies into other activities. Although she may maintain some dependency attachment to a person who has helped her, her interest in talking about the sexual assault may wane rapidly. She may become hyperactive in an attempt to renormalize and reorganize her life by participating in various activities. She may change her job, her school, or her living arrangements. The calm, supportive intervention of others can encourage her personality reorganization.

In this recoil or adjustment phase, which may occur within days or weeks of the attack, such maladaptive behavior as excessive self-blame, damaged self-image and confidence, severe agitation and depression, or inability to resume regular activities and relationships should be assessed to determine if continued counseling is indicated. This personality disintegration occurs rarely. When it does, it is usually because crisis guidance has not been available in the impact phase, or the victim's support system (family, friends) is not helping her, or she had substantial coping problems prior to the rape.

4. As the victim enters the *post-traumatic, or integration phase*, she may feel the need to be alone as she attempts to reconcile her thoughts and feelings about the rape. Often a victim will withdraw from counseling interaction at this time. Although she may continue to respond to outreach efforts, she will often indicate that she has nothing to talk about, or appear resistant. She is attempting to determine her own feelings about whether she has any responsibility in the crime and establish her anger at the rapist and others who have dealt with her insensitively. As this period of personal introspection continues, the victim may experience depression and a renewed need to talk to a counselor about her feelings. There may be a time of a pseudo-adjustment during which she is struggling to reorganize her feelings and lifestyle; she may feel she has made an adjustment only to find later it was temporary or unsatisfactory. The counselor can, in part, compensate for any inadequate response to the victim by family, friends, police officers, or medical personnel by providing both support and information. Consistent and regular counseling contacts will be beneficial here, and the victim may be able to resolve these personal issues in a relatively short period of time.

Depression and anxiety relating to the rape may be triggered in this phase by other emotional situations, such as other losses, anniversary of the rape, or even emotionally happy occurrences, such as marriage or graduation. As the time for the rape trial draws near, anxiety may reactivate fears or cause depression. Victims who have not sought or received crisis counseling before this phase may seek help at these times when their emotions are overwhelming. If during the time between the impact phase and the integration phase the victim has not received any help, it may be more difficult and take longer for her to resolve her conflicts.

B. Guilt

In general, guilt and self-blame, which are common responses to being raped, seem to vary in degree with the extent of physical injury and the type of association with the assailant. Women who have experienced severe physical injury during the rape seem to focus their attention on their injuries rather than on the rape; their guilt is not evident. They do not have to face the issue of their involvement in the rape because there is obvious evidence of their resistance. These victims can resolve their anger more quickly and feel justifiably sorry for themselves.

Victims of a "blitz" rape also have diminished feelings of guilt. The woman who was raped in her home feels guilty at not having protected herself sufficiently from a rapist and will obsessively review what she could have done to secure the premises better. The victim experiencing the worst feelings of self-blame is the woman who knows her assailant. She chides herself for poor judgment or seductive behavior and displays other self-hating characteristics. It is most difficult for her to resolve her guilt and conflicts over the rape. These guilt feelings may affect the severity of reaction to rape, and may also make a victim more susceptible to negative reactions from others, thus prolonging the time required for guilt resolution.

C. Intersection of Situational and Developmental Crises, Including Support Systems

Althouth sexual assault is viewed as a *situational* crisis, its impact will vary with the *developmental* stage of the victim, particularly in areas of task orientation, sexual development, interpersonal relationships, and support systems. Rape crisis counselors have observed behaviors and feelings consistent with a person's developmental stage that are visible in many rape victims, and should be considered part of the normal crisis reaction. So little is documented about the effects of sexual assault that it is advisable to view most reactions as normal, and to consider the victim in possible need of some level of counseling. Counseling services can facilitate her psycho-social adjustment and ease her way through a complex system of doctors, police, lawyers, procedures, and questions.

As the victim of any age attempts to adjust her social and psychological life to its prerape level, the support she receives from significant others and her general social network are of prime importance. Rebalancing her equilibrium becomes more difficult when parents, husband, lovers, and friends are ambivalent about her role in the rape, actively reject her, and are uncooperative or hostile.

Husbands and parents may ignore the wishes of the victim and report the crime to achieve retribution. Often their narcissistic hurt and anger supercedes their concern for the victim. Even if the victim's family seems to be mistreating her, it will not be helpful for the counselor to try to invalidate or discount the victim's loyalty to and concern for her family. It is important that these family members be given support and an opportunity to express and work through their feelings about the assault, the victim, and the assailant. This will often enable them to, in turn, meet some of the victim's needs during her period of acute reaction and reorganization. However, this is not always the case. Marriages are sometimes ended and teenagers leave home as a result of nonsupport from significant people.

It is important for the crisis counselor to help the victim find support, be aware of sources of nonsupport, and find ways of coping with both. The counselor might consider, with the permission of the victim, calling in significant people for joint counseling. In such times, underlying problems in relationships may rise to the surface and the family may be helped to face the problems and possible solutions. Although the woman or girl is the one who has been victimized, the impact on family and friends should not be overlooked–for its influence on the victim as well as on their own emotions and behavior.

Reinvolvement in normal tasks is a significant key to adaptive capacities for all victims. Because there is so little data on the actual psychological and social needs of the rape victim, it is useful to look at task designation and completion as signs of adaptation and compare the victim's current life to her prerape activities. For instance, is the victim shunning usual activities, such as school or employment, for long periods of time? Is she retreating from interpersonal relationships, particularly resumption of sexual activities? Does she find herself unable to get out of bed, go out alone? Initially, these would be "normal" reactions, with possible periodic recurrence. Counseling contact should be maintained to help the victim overcome phobias, nightmares, or displaced fears and readjust to a lifestyle that is satisfactory to her.

Rape can act as a catalyst, as can other life crises and losses, provoking the woman to look at her lifestyle and experiences, recognizing her dependencies and her abilities. As she assesses her experience, a victim may be susceptible to politicization in response to insensitive treatment she may have received from friends, husbands, lover, or parents, or in reaction to the society that condones and allows rape to continue unabated. Some intimate relationships may be ended, or cooled, often triggering other anger and loss of feelings in the victim. A woman then needs to integrate her outward anger, inward depression, and dissatisfaction with her lifestyle to re-establish comfortable relationships and activities. Many victims will undergo this introspection, and for them the rape has stimulated an input of information that may need to be handled by long-term counseling or psychotherapy. The victim should not be viewed as "sick," but the counselor should realize that her psychic and behavioral equilibrium has become unbalanced and usual psychological defenses are not operating effectively. Supportive and insightful counseling should enable her to make an easier, more direct resolution of conflict than she might if she struggled with these problems alone, and the victim may emerge a healthier person.

D. The Rape Victim Counselor

As a counselor it is important to remember that you cannot separate a person's experiences, personality, and lifestyle from the crisis of rape. When we talk about counseling a rape victim, we are talking about a whole person whose momentary focus is on a specific crisis or incident and whose future life will be somehow affected by this incident. The knowledge of this fact and the ability to deal with the victim as a whole woman is what differentiates a counselor from a police officer, an examining physician, or a district attorney. All these people can be understanding and sensitive to the victim in conjunction with the performance of their responsibilities. And the performance of these duties may contribute to the well being of the victim (through rapist apprehension, proper medical treatment). The counselor goes further in providing emotional support, concrete environmental manipulation, and a potentially insightful and maturing experience. The counselor must be prepared to pick out salient concerns and deal with them initially with decision-making is necessary. Concerns over family relationships, employment, school, and health will come up again, and the counselor can help the victim through further counseling or referral to appropriate people or agencies who can help her, if she so desires.

The counselor is also the only person the victim can refuse to talk with if she chooses to prosecute her assailant. Despite evidence that sexual assault is an unforgettable trauma, many women will choose not to be involved with a counselor, and this decision must be respected if all efforts to help her have been offered and refused.

E. What Is Known About Rape Victims?

Before the existence of rape crisis centers and publicity regarding the trauma of the victim, many thousands of women and girls were raped and somehow readjusted. It is not known how many sought mental health care, had serious personality disorganization, developed insurmountable fears and phobias, or broke off relationships and careers. What is evident is that mental health professionals have counseled few rape victims in their agencies or private practices. Although women statistically seek psychiatric treatment more often than men, it is curious to note this absence of sexual assault victims as psychiatric patients. Perhaps these women are not seeking help because their adjustment has been satisfactory or perhaps they remain ashamed and guilt ridden.

It is important to keep confidential but accurate information about stated and implied victim needs and responses. By analyzing this kind of information we can more appropriately determine the kind of counseling applicable to rape victims and attempt to provide it.

FOOTNOTES

[1] Erich Lindemann, "Symptomatology and Management of Acute Grief," *Amer. J. Psychiatry*, Vol. 131 (1944): 141.

[2] Robert Weiss and Henry Payson, "Gross Stress Reaction," from Friedman and Kaplan, *Comprehensive Text Book of Psychiatry* (Wilkens, 1967).

[3] James S. Tyhurst, "The Role of Transition States--Including Disasters--In Mental Illness," (Symposium on Preventive and Social Psychiatry, Washington, D.C., Walter Reed Army Institute of Research, 1957).

[4] Susan Griffin, "Rape--The All-American Crime," *Ramparts* (Sept. 1971).

[5] Sandra S. Fox and Donald J. Scherl, "Crisis Intervention with Rape Victims," *Social Work* (Jan. 1972): 37.

[6] Ann Burgess and Lynda L. Holmstrom, "Rape Trauma Syndrome," *Amer. J. Psychiatry*, Vol. 131, No. 9 (Sept. 1974): 981.

APPENDIX IV-D

COUNSELING AND AIDING THE VICTIM OF SEXUAL ASSAULT

[Suggested form for counselor training materials]

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Preface

These materials are an amalgamation of guidelines originally written by Virginia Crow for use by nonprofessional volunteers at Rape Relief, a feminist rape crisis center in Seattle, Washington. Ellen Barnett adapted the guidelines for training materials she used in giving technical assistance under this grant to Passage Crisis Center in Montgomery County, Maryland. It is hoped that in this form they can be used by other groups to train rape victim counselors.

COUNSELING AND AIDING THE VICTIM OF SEXUAL ASSAULT

As a counselor, you will be called upon to assist victims of sexual assault in a variety of ways. You will be first concerned about the feelings and well-being of the victim and her family or other people close to her. You may be concerned with the personnel in the sexual assault squad or other relevant section of the police department, the hospital emergency room, and the district attorney's office, some or all of whom will probably question, treat, or represent the victim. There is a great deal of information to absorb before performing this job; some of it will be unfamiliar to you. What is provided here is information about the reaction of a victim, her social and psychological needs, guidelines for accompanying her through the various systems, and information about her legal and medical needs and rights.

Your goals are threefold: (1) to help the victim assess her medical needs and decide whether she wants to report the rape to the police; (2) to assist the victim by attempting to ensure that she is treated properly, with dignity, that her immediate needs are met, and that plans are made to meet future needs; (3) to observe the workings of the legal and medical systems, noting where they could be improved to facilitate efficient and sensitive treatment of the victim and her family.

A. Ways [Your Agency] May Be Contacted

1. *The victim calls*. The victim herself may call [Your Agency] after the crime has taken place. This is truly a crisis situation, and you will need to help her make quick decisions and assess her physical and emotional needs. Elicit basic information, such as name, phone number, and address. Let her know you can meet her at an appropriate place decided by the two of you (hospital, police station, home, [Your Agency]). The possibility of police reporting and medical treatment are concerns to be dealt with (see following material). Advise her not to wash or douche or change clothes if there is any chance she will want to prosecute her assailant. If you will be meeting her some place other than her home, make arrangements for her to get a change of clothes if possible.

2. *The police call*. A patrol officer or someone from the sex offense investigation section of your police department may call [Your Agency] with the permission of the victim, either before or after they have interviewed her and she has been examined at the hospital. You will then meet or talk to the victim and/or her family, as seems appropriate at that time.

3. *The hospital calls*. The examining hospital emergency room may call, with the permission of the victim, either before or after she has been examined, before she has been taken to the police station for further questioning, or before she has returned to safe lodging for the day or night. Again, you will meet or talk to the victim and/or her family, as seems appropriate at that time.

4. *Family or friends call*. Family or friends may call, with or without the permission and knowledge of the victim, at varying times subsequent to the assault. Here you will need to find out when the assault took place and what other steps have been taken to notify police, hospital, or other appropriate people.

Remember that anything said to you about the victim by her family or friends should be kept in confidence, as, of course, is anything the victim says.

The victim/family/friends may call any time after the rape if they feel that they or the victim need counseling help or information.

In each of these instances your entree to the victim will be slightly different, and you will have to relate to other personnel or interested people according to who called you, their purpose in doing so, the needs of the victim, and the time that has elapsed since the rape occurred.

As a counselor/advocate, you are already familiar with (or are being trained in) counseling skills and the benefits of crisis intervention for the person in crisis. A rape victim is a person who may view herself in a state of crisis or stress, or merely as having a problem to solve. Experiences you have had with other people in crisis will serve you well in helping a rape victim.

B. When You Talk to the Victim

1. *Listening.* Listen in a way that supports and validates the woman's feelings, encouraging her to express whatever feelings she has, in whatever way she wants to. Her reaction will be based on her perception of the event in its social context plus her life experience in coping with other stressful events, as well as attitudes (toward men, sexuality, violence, self-esteem, etc.). Do not attempt to redefine the situation as being either more or less critical than she sees it. The victim is the only one who can determine how critical the situation is, since the determination must be based on her own values.

Initially, it is not essential that you understand precisely what she is saying or what actually happened or that you convey information. You must first determine if she is ready to hear about making decisions about treatment, reporting to police, calling relatives, etc. If you make supportive comments from time to time while she is talking, your understanding tone will be heard, and eventually her comprehension that you have some understanding of her feelings will make it possible for her to listen to you. It is helpful to reflect back to her the feelings she is getting across, or to summarize what she is saying to help clarify her feelings and thoughts.

You may have a strong feeling that the woman is blaming herself for what happened, and, if you are right, it is important to help her recognize and cope with the feeling. However, you need to be careful not to plant the idea of guilt where it does not exist.

If the woman has been crying and is very distressed, she will likely become calmer and slow down, begin to repeat herself, and ask about your role in this situation. In rare instances, her emotional state may begin to escalate to a degree that seems dysfunctional. In either of these instances, you would shift from a listening to a more active counseling role and assess the need to call a mental health professional or a doctor for consultation or medication.

If a woman calls saying she has been raped but then has difficulty talking further, tell her you would find it easier to talk if you were with her. Try to encourage her to tell you where she is so you might join her. You might also raise the question of going to the hospital or calling the police, if she has not already done so.

If she wants only to talk on the phone, you will want to assure her that everything she says will be kept in confidence, explain services [Your Agency] can offer, and again help her with necessary decision-making about medical and police intervention and treatment.

2. *Meeting the victim.* When you meet the victim for the first time, tell her immediately who you are, where you are from. If you have talked to her on the phone, remind her of your conversation. If someone other than the victim has called you, ask her permission to remain with her, telling her how you might be helpful to her. It is likely that [Your Agency] will be called after the victim has called the police or arrived at the hospital.

If you are working with a partner, as is recommended, you may split up, one talking with the victim, the other with hospital, police personnel, family, or friends. You will want to know what information the victim has been given and how you can be most helpful in talking with her and others who may either be present or need to be notified.

Of course, if you are meeting with the woman after the police and medical examination, her affective and emotional state may be considerably more subdued; she may be tired of talking about the rape and need help in deciding what to do next. Do not press her to talk about it, but help her make decisions about housing, transportation, or other immediate concerns.

If you begin to feel that you do not know what she wants, the best way to handle it is to let her know you are not sure what she wants you to do. Explain what you can do. If she still does not respond, you may need to ask her specific questions about where she wants to sleep, does she have children in need of care, does she have a prescription that needs filling, does she have family or friends she would like to call, etc. Your main concern is with her well-being for the rest of that night or day. Follow-up plans can be made after she has had a chance to rest and collect her thoughts.

3. *Helping her make decisions*. Help the woman clarify her problems and focus on action that needs to be taken in regard to medical treatment, police reporting, or other problems that may have developed as a result of the rape.

This clarification and differentiation of problems will help the woman lower her anxiety level by regaining a sense of control over her life.

There are several ways you can assist the woman after she decides to seek medical aid or to report the crime to the police.

C. Seeking Medical Treatment

Medical treatment should be offered to the victim for two purposes: (1) treatment of injury, VD prophylaxis, and pregnancy testing; and (2) collection of evidence for possible prosecution of the rapist. If she is considering reporting the crime to the police, be sure to tell her not to wash, douche, or change clothes before the medical examination.

1. *Medical examination*. You may be asked to meet the victim at the hospital or her home prior to her medical examination. The victim needs to know the purpose of the examination, as it will have a direct effect on her decision to report the crime to the police for investigation.

There are a number of questions to ask and subjects to discuss with the rape victim before the medical examination takes place. Some of this may have been done on the telephone, but as you talk remember that under the best of circumstances, it is difficult for many people to understand medical matters, and a person in stress may miss a lot of what you say. As you listen to the rape victim's responses, be alert to whether she has really heard you and do not be afraid to ask if she has understood. Repeat the information whenever you think it might help. You should have a written list of medical procedures and information that you may share with her at this time.

There is a mystique about the medical profession, which is intimidating to many people. Women, especially, often feel dependent and ignorant in the presence of a doctor. The pain and emotional distress experienced by a rape victim increase her feeling of vulnerability, which may, when combined with the doctor's use of unfamiliar vocabulary and instruments, overwhelm her with feelings of helplessness.

When the victim has adequate information from you on what to expect and what her rights are in the situation, her anxiety and helplessness will be significantly reduced. Use whatever time you have with the victim to give her that information and to respond to the concerns she expresses.

It is also possible that the police or emergency room personnel have given information to the victim about the imminent procedures. However, do not assume that this has been done. Ask the victim if she knows what medical procedures will be occurring and why. Even if she heard it once, she may need to hear it again from you. Often the hospital and police personnel are too busy or not well informed enough to give this information in a reassuring, slow manner. Be aware that a new standardized medical protocol is being developed; it will eventually affect hospital procedures. When it is in full use, most personnel will have a better understanding of procedures.

Knowledge of what is to be done will help reduce the victim's anxiety and helplessness. Many victims may never have had a pelvic exam before; these women may be frightened by the prospect. If you have time, you may want to describe the exam to her.

Most of your preexamination conversation with the rape victim will probably take place in a hospital emergency room, where you may wait for half an hour to up to two hours. The wait may be quite short, so try to cover necessary topics briefly and then return to those that seem most important or troubling to the woman.

If there are nurses, police officers, and family all hovering around the victim with questions and solicitiousness, observe where you can be the most helpful. Observe the behavior of the professional personnel as well as the interaction between victim and others, as this information will be helpful to both you and the victim later on.

A police officer may also meet the victim at the hospital to ask questions about the attack for an immediate chance to apprehend the assailant. It is possible this officer may also provide information to the victim about the police and medical procedures.

2. *Hospital procedures*. If you are arriving at the hospital with the victim, go to the designated reception area, where the clerk on duty (who may or may not be a nurse) will probably take down a minimal amount of information (name, address of patient and next of kin, what the physical problem is, when and where the rape occurred). Explain to the patient, if you have not already, any possible arrangements that can be made in your locale for paying her medical costs. (For example, in some areas the District Attorney will pay for the collection of evidence examination if the victim has chosen to prosecute the assailant. In others there may be some type of victim compensation legislation.) If the victim has arrived before you, be sure she is supplied with this information.

There will probably be a nurse and the examining physician in the examing room. A female police officer may also be present. Tell the victim who will be with her, and if she is distrustful of these people and anxious about the exam, suggest that you might remain with her, if she would be comfortable with that idea. It is likely that the hospital staff will not go along with this, and it is up to the victim and you to be firm about her reasons if this is her wish. She may be just as distrusting of you as of everyone else, so be careful not to impose yourself on her, particularly if you have just arrived at the hospital and have not had time to develop any rapport with her. Obviously, only a female counselor should suggest staying with the victim during a medical examination.

If you are not to be present in the examining room, which is most likely the case, it is important that the victim has been well informed about the medical procedures for collection of evidence and treatment for VD, pregnancy, and/or other injuries, prior to and following the exam. Of course, a severely injured victim will be expeditiously treated for her injuries and may not have had the chance to talk to anyone at all. Again, you cannot assume that this complex area of medical treatment has been explained. Do not be afraid to ask her again if she understands what is to happen (or has happened). Give her a medical information sheet explaining each item. If she has concerns about pregnancy or VD, be sure she has the necessary information to make the complex decision about treatment.

3. *Questions about the rape*. Ask the woman about the kinds of sexual contact that took place. Explain to the woman that if there was contact between the man's penis and her mouth (fellatio) the doctor will need to take a throat culture for gonococcus (gc), and she may need treatment for a sore throat, as well. If there was anal intercourse, the doctor will need to examine her anus for injuries, and even if there was "only" vaginal intercourse, the doctor should take an anal culture also. (These tests, however, need not be done immediately after the rape, unless there is a possibility of the woman reporting

to the police. If that is definitely not a possibility, it is better to have the gc tests done four to seven days after the rape, for greater accuracy and to save money.) There is also no possibility of getting VD from cunnilingus (contact of the rapist's mouth with the victim's vagina), so there is no need at this point to ask about it, but later the woman may find it a useful catharsis to discuss it.

It is very important how and when you phrase questions about the rapist's behavior, particularly sexual behavior other than "straight" vaginal intercourse. Do not ask these questions until you have explained that the doctor will need to know, and that you may be of more help to the woman in dealing with the doctor (if she wants you to) if you know what occurred. If you ask the question before she understands the need for it, you may get an automatic "no" answer because the woman is likely to feel especially humiliated by such experiences. Once having said "no" the woman may feel compelled to stick to that answer.

DO NOT leave the burden of describing what happened up to the victim by asking an open-ended question like "Was there any other kind of sexual contact?" Embarrassment or ignorance of "correct" terminology may lead the woman to mumble or say "no," regardless of what took place.

AVOID phrases that the woman may not know (fellatio, cunnilingus, etc.) and phrasing that has the connotation of ordinary intercourse or lovemaking, or that sound as if the victim took some initiative. Examples of what NOT to say: "Did you and the rapist have intercourse" or "Did you put your mouth on his penis?" Questions of this sort may increase feelings of guilt or shame and make it impossible for the woman to give an honest answer.

You might ask "Did the rapist . . . penetrate your vagina," "put his penis in your mouth," etc. That phrasing puts the responsibility on the rapist, but is somewhat more graphic than a passive construction such as "Was there any contact between the rapist's penis and your mouth?" The latter phrasing tends to depersonalize the experience and may help to defuse the woman's emotions if she is very upset.

Later, you may want to talk with the victim in a very different way about the experience and to encourage her to talk about the fact that it really did happen to her, but at this point she probably has enough to deal with in undergoing the examination and, possibly, talking to the police. As always, however, you take your cue from what she feels will be useful to her.

4. *Medical treatment choices*. Ask the woman how she feels about the DES (morning after treatment), menstrual extraction, and abortion, if appropriate. You should help the woman determine whether there is a possibility of her being pregnant. If there is, discuss with her the controversial aspects of the DES treatment. Let her know that there are differences of opinion and much that is not yet known. It may be difficult for the patient to understand your explanation, but if she is wary of taking drugs about which little is known, your conversation with her may be her only opportunity to make an unpressured decision. The doctor will very likely not discuss pros and cons with her. If DES is not routinely given in your hospital emergency room, and if she wants to take it, let her know how to obtain this treatment.

You should also discuss her feelings about menstrual extraction and abortion so that she can consider all possible alternatives together. If you can, tell her that you can help make these arrangements if it becomes necessary.

5. *Nonmedical questions, medical release forms, other questions*. Ask the woman if she is willing to answer questions that are not medical but may be pertinent if she prosecutes the rapist. If the woman is fairly certain she will not report the rape to the police, remind her that it is difficult to make the decision when she is feeling upset. Tell her that many women change their minds about reporting during the first day or two and that even within the next 24 hours after a rape, valuable evidence may be lost. Be sure she understands that any evidence taken at

the hospital cannot be used in court unless she signs a release form. All these things should be explained as aspects of one alternative, but one that leaves open the options of prosecuting and not prosecuting, which may be considered at length when she is more clam. Although it is true that there is a bias against late reporting, it is not nearly so great when the woman has reported to a hospital or crisis center, and evidence has been acquired fairly soon after the rape.

Ask the woman if she is willing to sign a medical release form and find out if there is any information likely to appear on it that she might not want released. If the woman signs the release form, all information obtained through the doctor's questioning or physical examination may be available to the police and prosecutor, and some of it may be made available to the defense attorney. The information released is only for the examination on the date in question, not for her medical history; nevertheless, some women may be understandably concerned about releasing it.

A doctor may ask a woman if she is using birth control pills, in order to determine the likelihood of her being pregnant. If the fact that she is using them is put in the record, this fact may be used later to slur her "moral" character in court if she is unmarried or quite young.

The rape victim should know before she is examined that she has the right to ask the doctor why she/he asks a question and whether it will be included in the record which she may later release. She has the right to decline to answer any question she is asked. Most women find it very hard not to answer all questions under these circumstances, so you should find out how much help she will want from you.

Ask the woman if she is willing to answer questions that are nonmedical and of no legal relevance. The rape victim should know that many doctors and nurses–often with the best of intentions–ask questions about the circumstances surrounding the rape. The motivations of medical personnel may include the belief that they need information in order to advise the victim on reporting to the police, or the conviction that the woman needs to talk about it as a catharsis. They may also question the victim as a way of handling their own anxiety or their need to express sympathy.

Because of the medical mystique referred to earlier, women readily assume that doctors are experts on dealing with emotional problems and are knowledgeable about rape and the law.

Find out how the woman feels about discussing nonmedical subjects with the doctor. If she has a family or personal doctor, therapist, teacher, or other person close to her, she may want to call him/her to discuss these issues and concerns. She may be able to share her concerns with you. You can respond to them directly or refer her to one of these other people to help her the next day.

If a woman is seeing her own doctor, she may assume that the doctor will be sensitive to her feelings, and she may be shocked to find out during the examination that her expectation was unfounded. You can prepare her for this situation by making some general comments about the range of reactions to rape among different people, including doctors, family, and close friends of victims. This may also be a good time to find out how supportive her environment is. (Does she have friends, relatives, a rap group, a therapist? How reliable are they going to be if she wants to talk about what happened?) Later, if her doctor unexpectedly "scolds" her for hitchhiking, or asks insinuating questions, she will be able to put it in the perspective of society's lack of understanding, rather than accepting the comments as evidence of her quilt.

Point out to the woman that even if she does not choose to talk about the rape now, she may want to later, and she will probably find it useful to find one person she feels very secure with to tell the whole, detailed, ugly story to, at least once. Offer to be that person if she wants, and ask for permission to call her later in case she wants to talk about it. Be sure she understands also that she can call for other related reasons, and that you will not pressure her to talk more than she wants to about the rape. Give her a card from [Your Agency] with your name and shift on it, and also advise her that there will be someone there to talk to her, even if you are not.

Ask the woman if she wants to know what is going on during the doctor's examination. Find out if the victim is one of the women who believes that medical knowledge represents power. There are still many women who prefer not to know what is happening, and these are often the same women who believe it is a weakness to admit pain, or that they should not make the doctor's job more difficult by complaining.

It is not your job to change the woman's attitude, so be careful not to make her feel she has an additional problem of trying to accommodate herself to your value system. To the extent that you understand and respect her values, you will maximize your ability to help her.

Your conversation with the woman up to this point should have given you a good idea of how the woman feels about herself, about whether it is important to her to be in control, and about the level of her self-esteem. If you do have a clear idea of those factors, you will be an effective advocate for her.

6. *Communicating with the medical staff.* Your job as advocate will be greatly affected by the way you are received by the hospital staff. There may be situations in which the patient is made to feel unnecessarily uncomfortable, and your presence and assistance to her may not be warmly accepted by the hospital.

The problem of being an advocate is basically the same in a variety of situations. You are there because the woman may lack either information or enough assertiveness to get what she wants from the situation, and because she could benefit from an empathic, supportive relationship. The need for advocacy arises most frequently when a person is trying to cope with an institution that has an authoritarian aura, enhanced by the mystifying effects of a language most of us do not understand.

Authority figures, accustomed to having their judgments and advice unquestioned, may feel threatened when even innocent questions are posed. They may feel imposed upon in having to "translate" from the language of their professional disciplines to a lay person's language. They may be simple baffled by your presence.

You will not be a very useful advocate if you are threatening to the "expert." You should, therefore, try to put her/him at ease by explaining who you are and why you are there: "I am Molly McGuire from [Your Agency]. Ms. Henderson has asked me to stay with her during the examination."

The problem of "titles" is important symbolically and psychologically to many of us. It is suggested that you introduce yourself to the doctor, using both first and last names, because it is more friendly than "Ms. McGuire," but does not necessarily give permission for the doctor to address you as "Molly." At the same time, if you refer to the patient as "Ms. So-and-So" you give the doctor a subtle message about status, and you do not risk being offensively familiar to the woman. Each counselor will have to use her/his judgment here and do what she/he feels is comfortable.

In many hospitals you may encounter a policy of "staff and patient only admitted to the examining room." In these instances, you will want to know who will be in the examining room with the victim so you can try to reassure her of the treatment she will be receiving. If a female police officer will be present in the examining room to collect the medical evidence from the doctor, find out from the victim how she feels about this procedure and help her express these feelings to the physician or the police officer.

D. Reporting to the Police

The victim, or you, with her permission, may call your local emergency number (911 in many areas) for an immediate police patrol response. Following that, the police department may send an investigator (detective) from its sexual offense section that investigates rape cases. If the victim contacts the police, you might let her know that you could accompany her to the stationhouse, possibly sit in on her interview, and certainly talk with her family/friends at that time, if she wishes.

Keep in mind that the rape victim is going to live with the guilt or fear that may be the result of reporting or not reporting. Therefore, you can only give her information that will help her make the decision, and support that decision. If a woman is uncertain about reporting, in the immediate crisis situation, she can give the details of the crime to you.

In many areas, hospitals automatically call the police. This is unfortunate because it robs the woman of the opportunity to choose to wait before deciding whether or not to report the rape. If she does not go to the hospital, because they will report, then evidence will not have been collected for later use if she changes her mind in a couple of days and wishes to report then. Some police departments will take an anonymous report from a community agency to contribute to modus operandi files, and to keep if the victim changes her mind about reporting. You might check this possibility.

1. *Reporting to the patrol officer.* [Your Agency] may be called by the police after their initial interview with the victim. You may, then, be meeting her at the hospital, the police station, or her home. However, if the victim has called you first, and you have met her before the police have arrived, give the rape victim time to introduce herself and you to the patrol officer. Very often she will expect you to explain why the police were called, and it is all right to do it, but never take over any control of the victim's role unless it is clear that she is unable to and wants you to.

At the earliest opportunity, give the police officer your name and say where you are from. If she/he looks puzzled, say it again and explain that [Your Agency] gives aid and information to rape victims while they go through medical and police procedures. Try to get the officer's name by asking in a very nonthreatening way. A soft voice and a phrase like "May I have your name?" or "Would you tell me your name?" is better than "What is your name and badge number?"

Sometimes the police officer will sound unnecessarily brusque, unsympathetic, or skeptical because it is the end of a long, wearing shift, or because she/he is embarrassed at the whole situation and has never interviewed a rape victim before. She/he also may not realize that some necessary questions will sound accusatory if the woman does not know why they are being asked.

Ideally, the police officer will explain the necessity of asking certain questions, but often that does not happen. If you have prepared the woman for the questions beforehand, it will help. For instance, somewhere along the line the victim may be asked when she last had intercourse. If they have found traces of semen, they may legitimately want to determine if it is from the rapist or someone else. Some police may ask if the rapist ejaculated. It is unlikely that such information will contribute to an identification, but some police officers may honestly believe it does.

The same principles apply in dealing with police personnel as in dealing with medical personnel. Prepare and support the rape victim so that she can be as assertive as possible. Give her opportunities to state her needs and wishes to the person examining or questioning her, and speak for her only when it is essential to her well-being. Be supportive of her, listening to her and giving her comfort and information.

If the police ask questions that seem unreasonable, and you sense the victim's discomfort in answering, you can say to her, "Would it help you in answering if you knew why it is being asked?" If she says yes and the police officer fails to respond with an explanation, you may then say to him/her, "It would make it much easier to answer if you explained to Ms.____________________ the reason for the question."

The police officer may ask just a few questions and may write a few words on a scrap of paper. This does not necessarily mean that he/she is not taking the information seriously. She/he will most likely write it all out on the proper report form when she/he returns to the police car. There is a great deal of discretion in how much information is taken at the scene or immediately thereafter, and there are advantages and disadvantages to a lengthy report.

a. *Advantages of lengthy early report.* It may be easier for the victim to recall details (especially of the rapist's appearance and things he said) more accurately at the time than two or three days later. Relating the events at this point may be a catharsis, helpful in reducing feelings of guilt, anger, and fear. (Although anger is likely to be helpful to a rape victim, uncontrolled and unfocused hate will not be if it continues for very long.)

b. *Disadvantages of lengthy early report.* Because the victim may be extremely disturbed and confused, her story may be jumbled, contain contradictions, and differ in details from the story she tells a few days later. (Those details may be unimportant, but they may prejudice her case.) This is especially true if she has taken any drug or had several drinks.

If the victim is feeling guilty or embarrassed at having to relate the rapist's sexual behavior, or if she is tearful, it may be quite painful and humiliating to have to give a lengthy report. It will be less so a few days later when she is in more control.

Although reporters are generally fairly discreet in what they print about a rape, they sometimes pick up unusual aspects of the situation. Even though it is unlikely that what they print will identify her, there always is that possibility, and the less that is printed, the better she will probably like it. Although the Supreme Court has ruled that newspapers do have the right to print a rape victim's name, they rarely do.

If the woman is worried about what will be printed in the paper, suggest beforehand that she ask the patrol officer that she would like to answer just the few essential questions that are absolutely necessary and that she will be better able to answer in more detail in a couple of days when she is more calm. If that is clearly what she wants, but is unable to say it, say it for her.

2. *Talking with the family.* If your agency is called after or during the police interview, your role will be slightly different than that just described. Your initial goal will be to find out from the police officer what has happened, who is with the victim, and how you can help. Ask whether the victim knows you are there and wants your help.

You may be asked to stay with family or friends of the victim while the police are interviewing her. In this instance, these people will need the chance to express their feelings, fears, anxieties, and anger, and will want to get as much information as possible about the assault. You may have to go back to one of the officers to get this information or to ask her/him to spend a few minutes with the family to explain recent events to them. You may find yourself feeling angry or hostile towards unsympathetic and accusatory family/friends. Despite your negative response, it is important to allow them a chance to "ventilate" their feelings and to calm down and assess the situation before they join or rejoin the victim. Their feelings are valid even though their own hurt and anger may temporarily supersede their concern for the victim. Destructive family reactions are difficult for a counselor to deal with, and you may find it appropriate to confront the family/friends with their attitudes if they persist after they have had an opportunity to ventilate.

After the police interview with the victim, you will want to talk briefly with her, telling her who you are, what you are doing there, who called you, and what you can do to help her.

You should, of course, have her permission before you make any arrangements for her. In this moment of confusion you may only have time to ask if you can call her the next day. Give her [Your Agency's] card, as well as one to family/friends to whom you have been speaking. Be sure she is satisfied with her housing and transportation arrangements and assist her in making them if she is not. You may see tremendous intrafamily conflicts arising at this time. Observe and remember what you see, but concentrate on the immediate needs of the victim. Serve as a clarifier and a facilitator so that decisions can be made and action taken on immediate concerns. You may need to attempt to defuse or postpone expression of intrafamilial conflicts in order to make satisfactory arrangements for the victim.

3. *Steps in prosecution*. The report to the police is only the first step in prosecution. If the rapist is apprehended, there then follow identification of him, interviews with the district attorney, preliminary hearing, grand jury hearing, pretrial conference(s), arraignment of defendant, pretrial motions, and the trial. This process can take up to a year, although attempts are being made in some jurisdictions to handle the cases more quickly. The victim needs to be aware of this process, at least superficially, to enable her to make a decision. In making this decision, it is important for the woman to evaluate how supportive her social environment is, how prone she is to guilt feelings and fear, how stable her self-esteem is, and how she withstands pressure. For example, threats may be made by the rapist.

E. The Victim's Other Needs

The counselor should determine if the victim has other immediate needs. How these are handled will depend upon [Your Agency's] and other community resources. These are some possible needs:

- Transportation to or from the hospital, police station, or home.
- Housing for the immediate night or day, and possibly the next few days. A victim may not want to return to her own apartment, particularly if she lives alone.
- Contact with family or friends who would be comforting and helpful. There may be various reasons that a victim may not want to be with her family. You need to make a quick assessment of these reasons and actively help her make the decision. Fears of parental or husband reaction may be overestimated, or they may be real, but they need to be dealt with.
- Child care. Was the victim raped at home, on her way home, leaving her children without anyone to care for them? In some instances where the victim is with the police, the counselor may find she/he is most helpful remaining at the home with children, waiting for the return of a spouse, etc.

F. The Victim's Feelings

1. *Feelings of guilt*. The rape victim's feelings of guilt are difficult for her to deal with and would likely have an effect on her decision to contact the police. Many women have internalized the prevalent mythology which emphasizes the idea that women are to blame for having been raped. ("She must have asked for it." "Well, what was she doing there in the first place?" "She was 'leading him on' so she deserves what she gets.")

No matter how strongly you feel that it was not the woman's fault, it is important to let her talk and try to help her define in precise terms what she might have done "wrong"—and what she might have done differently. She may need to talk about it a number of times, and over a period of weeks or months, before she is able to consider the possibility that it was not her fault, but the rapist's. Regardless of the fact that she may have acted carelessly (i.e., hitchhiking) or without good judgment (leaving her front door open at night), she should, in time, be able to view the rape as a crime committed against her, for which the rapist is to blame.

In discussing her feelings with her, you may want to talk about some of the general mythology about rape (i.e., women being responsible for male sexuality, engendering violence in males, etc.) and contrast it with your opinion (if it is your opinion) that the rapist is accountable for assaulting her. You need to make it clear that you are expressing only your own opinion, and that you are not trying to invalidate her feelings.

Part of this discussion may center on varying lifestyles and the trade-offs that are made for living in a certain way. A woman who wants to be independent and mobile takes a certain amount of risk of being assaulted. It is not her fault for being assaulted, but she has become a more visible person and, thus, more subject to rape. Living alone, hitchhiking, going to restaurants or bars alone are all acceptable behaviors, but all may have certain consequences which a person should be aware of. Looking at alternative lifestyles, helping a woman realize that there are trade-offs for her decision, may help to give her a sense of control over her life and decisions about how to live.

Along with feelings of guilt and shame may be a desire not to share this traumatic experience with anyone for fear of their reaction. Help the woman think about people in her life who will help her feel good about herself and who will not contribute to her guilt feelings. Also, reassure her that you are available to talk with her at [Your Agency], and that if you are not on shift there will be an understanding person there to talk to or be with her.

2. *Feelings of fear.* Fear is another frequent reaction to rape or attempted rape. Normal fear response may be quite generalized or very specific to a threatening situation or person. The victim's fear may be particularly strong if the rapist has threatened to harm the woman again, as often happens if he suspects she will report to the police.

Help the woman express and specify her fear. Encourage her to list all the things she could do to protect herself, including some things that are unacceptable to her, such as staying home all the time behind heavily locked doors. The range of ideas may be from triple-locking all doors and windows to not going out alone at night or during the day, not drinking alone, or not hitchhiking. Again, this is another opportunity to point out that there is a range of choice, each with its price. Awareness of choice gives a sense of control, which reduces the fear.

3. *Denial of feelings.* Days or weeks after the rape, a denial of feelings may be followed by depression and anxiety. It is not clearly documented how many women react in this manner, but it is important to get the victim's permission to call her in a day or two, and keep in touch with her to help her decide what further services she needs. A woman may also experience somatic complaints (loss of sleep, appetite, gastrointestinal problems, sore throat, tiredness, lack of sexual desire). These may be seen as "normal" reactions. If they are of concern to the victim, talk to her about seeing a physician for medication and/or examination. You can refer her to [community health resources] if she does not have a family physician or does not want him/her to know about the rape.

There is no way you can anticipate all situations or all reactions of rape victims and their families. Since there are a variety of ways in which [Your Agency] may be called upon to assist the victim, her family, or even the police, you will need to make quick, accurate assessments of her needs and be knowledgeable about community resources. Try to be aware of your own strengths and weaknesses in dealing with these open-ended situations. (Are you embarrassed to talk about sexual matters? Do you think women should not be out alone at night? Do you disapprove of premarital or extramarital sexual intercourse? Do you get angry and impatient with nonsupportive parents or spouses?) Unless you have had to deal with these touchy issues, you may not be fully aware of what your feelings are, or how you would use them. As you become aware of your feelings and attitudes, the chances are that you can overcome them and/or use them in a constructive way.

If you are feeling anxious or confused in dealing with the victim and her family, the police, and the hospital, you will not be alone in these feelings. You may state what you are confused about and find that everyone else is, also, or that someone present can clarify what is happening. The victim and her family/friends will be looking to someone to help them clarify the situation, and it is useful if you can do it. Do not be embarrassed to ask questions of the police officer, or the emergency room nurse, or the physician, if the situation is unclear. Remember, you already have an idea of what is supposed to be going on, and if it is unclear to you, it is probably even more unclear to others.

You will want to assure the woman of the confidentiality of her contact with you. Remember that many women are ashamed and embarrassed that they have been raped, and they need to know that you will not discuss this situation with anyone without permission (i.e., to make a medical, mental health referral, etc.). This is particularly important if a third party has contacted you about the victim. That party as well as the victim should know that you do not want to hear anything that the victim does not know is being said. However, if a family member or friend makes the initial contact and is the one seeking help, the same confidentiality applies to that relationship.

G. Follow-Up Contacts

Your contacts with the victim after the assault will have some specific purposes:

1. A call within 48 hours to let her know you are still concerned, interested, and available to talk with her. Find out how she is feeling, physically as well as emotionally. How have family and friends been reacting? What has she been doing with her time? Does she feel like returning to school/work yet? (Most young victims take as much as a week from school.) You will be assessing her needs for further help from you.

2. The initial follow-up call will give you a general idea of victim needs. If you do not hear from her, call again in about a week. If she remains withdrawn, sullen, unwilling to talk, ask if you can call her again. Let her know you will call in about three weeks if you have not heard because you will want to remind her of appropriate medical follow-up: VD, pregnancy, etc.

3. Do not be surprised if the victim does not want to hear from you, has nothing to say to you. Just reassure her of your availability and that you will call again. Let her know you will talk with her family, friends, school, or whomever she may indicate she is having trouble with, at her request and with her permission.

4. You may find she becomes like other persons you have counseled. Other life concerns and activities will become evident, and you may learn about underlying interpersonal and intrapsychic problems that existed prior to the rape and are becoming exacerbated. Counseling at [Your Agency], local youth services, or other mental health facilities may be appropriate. Do not rush her into mental health treatment unless she seems anxious to have it. It is not helpful to imply that being raped drives one crazy, but it is helpful to note that nightmares, phobias, and interpersonal problems can be more easily dealt with in a counseling relationship, and she may want to share some of these feelings and hard times with an understanding person.

5. Six weeks from the rape you will want to remind her of appointments for medical check-up. It is advisable that an appointment be made in advance, if at all possible.

Some victims may feel that they are imposing on you and, therefore, will not call you to ask for additional help. You should assure the victim that she is not a burden and that you want to have her phone number so you can call her to know how she is getting along, as well as to help her make arrangements for the follow-up procedures mentioned.

Before you start feeling overwhelmed by all these do's and donts', try to remember that rape is a crisis like other crises, exacerbating existing problems, forcing persons to focus on themselves, their lifestyles, their fears, and their anxieties. Your counseling skills and common sense will help you help this woman. Do not hesitate to seek counsultation with rape victim cases. Rape remains an emotionally charged situation, and you may find yourself overcome with your own feelings about what has happened. It is also important to remember that very little has been substantiated about how rape victims react. You may find this particular victim acting contrarily to what you have just read, and you may want to check it out, share your observations with others, and bring a different viewpoint into focus.

APPENDIX IV-E

FUNDING SOURCES AND PROPOSAL WRITING

FUNDING SOURCES AND PROPOSAL WRITING

The following suggestions are directed to individuals or organizations unfamiliar with the proposal writing, fund seeking process.[1] They will not provide a thorough education on the subject, but are intended as an outline of the major considerations in proposal writing. More detailed and specialized treatments of the issue are referenced at the end of the appendix.

A. Identifying Funding Sources

- Some resources useful in locating the foundation or agency most suited to your needs are listed at the end of this appendix.
- Potential funding sources should be asked for information about their interests, programs, and operating styles.
- An initial letter or abstract could be submitted to these sources for reaction and comment, then one or two likely sources selected.
- Any formal application forms should be obtained.
- Personal contacts with these primary target funding sources will elicit suggestions; follow them.

B. Federal Funding Sources and Private Foundations

Both government and private funding sources encourage making preliminary inquiries before presenting a complete proposal, and both require the same basic information about a proposed project. They want to know the need, the objectives, the means for implementation, the relationship to other programs, the resources and personnel available, and the evaluation techniques.

Boards or selection committees make the final determinations of what will be funded. Private foundations are more flexible than government agencies and will sometimes fund more innovative ideas. Federal application forms and procedures are much more complex and require more detailed budgets.

1. *Federal Funding.* In initial contacts, learn how much money has already been allocated and for what purposes. What will be available? If nothing at one agency seems suitable, ask contacts to recommend some other source of federal funding—another agency or department. (This is not the procedure to follow with private foundations, however. Do not ask them to recommend another foundation unless matching funds will be needed to supplement the amount they are willing to give your organization.)

2. *State funding.* State agencies often administer Federal monies. Application is made to the state agencies, even though the funding is Federal. State legislatures sometimes have monies to allocate.

3. *Private foundations.* There are several kinds of foundations:

a. *Broad-purpose foundations.* These are the most difficult targets usually, because they are well known and deluged with applications.

b. *Special-purpose foundations.* Good sources, if project's purposes match theirs.

c. *Company foundations.* There is no directory available so it can be difficult to locate these foundations.

d. *Family foundations.* The programs of these foundations often follow the personal interests of the family.

e. *Community foundations.* Serve a special geographic area and must be convinced that the project will fill an unmet need of that area.

f. *Wealthy individuals.* Highly personal, with specific interests.

Learning about funding sources takes time and is an extremely important precondition to proposal writing. After identifying target agencies or foundations, find answers to the following questions:

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[1] This appendix draws heavily on "Some Information on Writing Proposals for Federal, State, and Private Funding," California Commission on the Status of Women, 1974.

- Does the agency or foundation make awards in a specific geographic area?
- Does it support public or private institutions, or both?
- What are its program priorities?
- What is the maximum grant ceiling?
- When does the board or selection committee meet, and how far ahead must a completed proposal be presented?

C. Developing the Proposal Idea

The project idea should be discussed with a representative of the foundation or government agency before a complete proposal is developed. Federal funding sources often have regional staffs who perform a liaison function. If a staff member becomes interested in the project, he/she may be a great help in developing a fundable proposal.

Advantages of such contact are major ones:

- Complete development of a proposal takes a great deal of time and sometimes a great deal of money. It can be time wasted unless it is geared intelligently to the needs and requirements of the funding agency.
- An interested human contact and a well-prepared proposal are the most important factors in winning funding. They help make one proposal stand out from the deluge received by any funding agency.•

Other forms of outreach are important:

- Determine if other agencies or groups in the community are interested in participating in the project or support its goals.
- Discuss the idea with potential participants or sample opinions of the population to be served by the project.
- Prepare an initial draft of the project idea and circulate it to key support groups, board of directors, any relevant policy-making body for comment.

D. Initial Query Letter

The query letter should not be longer than two pages and should cover these points:

- The need for the project; its local, regional, national impact.
- Previous work on the subject by the applicant.
- Other support committed on the project.
- Applicant's credentials in the field.
- The personnel for the proposed project.
- The project procedures and design.
- The time schedule.
- The total amount of funding requested.
- Plans for reports or publications.
- How the project relates to the funding source's programs or general purpose.

The first paragraph is vital. It should tell who the applicant is, identify tax-exempt status, briefly describe the project, and tell how much it will cost.

The letter should indicate personal commitment. Foundations fund people, not projects.

A final and important point: have the letter signed by the chief officer, chairperson of the board, or executive director.

E. The Major Parts of a Proposal

The proposal is developed in its final form after initial letters and contacts. It should be short, clear, and accurate. The writer might be helped by obtaining some sample proposals from other groups.

1. *Title page.* The following items belong on the title page:

a. Project title. The title should describe the goal of the project in words that are easily remembered. It should be descriptive of the project objectives and be as short as possible—6 to 8 words.

b. Name of contact person or project director.

c. Name of agency, foundation, etc., submitted to.

d. Inclusive dates of proposed project.

e. Total budget request.

f. Signatures of authorized personnel approving submission of proposal.

2. *Abstract of summary.* Briefly—in 200 words or less—state the reason the project is being developed, its objectives, and procedures. Although the abstract appears early in the proposal, it should be written last.

3. *Problem statement.* In one or two paragraphs, state what needs to be done, and why. State the local or national importance of the project, and include references to related research or previous projects that establish the need for the project. Clarify the relation between the funding source's goals and the project. The project goal, described in broad, general statements, is included in this segment. Do not overstate or promise results that are too sweeping.

4. *Objectives.* The proposed outcomes of the project should be stated in clearly specified and measurable terms. The objectives must have a direct relationship to the need or needs identified in the previous section.

5. *Procedures or methods.* This section defines how the objectives will be met, and should be specific on day-to-day operation.

a. *The design.* The approach to be used in carrying out the project should be described. It is usually presented first in general terms and then broken into specific activities. The design must be well thought out and may be presented in a number of ways: (1) activities tied to a specific procedure can be grouped together; (2) activities can be presented by functional categories, such as planning, development, and implementation; or (3) activities can be described in major time blocks, such as the first three months, second three months, etc.

b. *Participant selection.* The population to be served should be identified, and such details included as whether the entire population or units within it will be involved, how the project participants will be selected, and whether or not they will be volunteers.

c. *Timing.* The sequence and amount of time allotted to the major project activities are indicated here. A realistic judgment of what can be accomplished within a particular time is important. Some proposal forms require a time/expenditure-of-funds relationship chart.

d. *Administration.* Overall administration of the project should be outlined. An organizational chart, in addition to narrative, could include: (1) the organization of the project staff, (2) the relationship between the project and the applicant agency, and (3) the role of advisory bodies.

e. *Personnel.* A detailed description of how many and what categories of employees will be needed for the project, and how they will be recruited and selected, should be included. Provide background information on key personnel as evidence of the applicant agency's experience, expertise, and general managerial or professional skill.

f. *Facilities.* Facilities required for carrying out the project should be described, along with how they will be provided. If special equipment or facilities that enhance the operability of the project are available to the applicant agency, describe them.

g. *Products or outcomes.* Even though what will be accomplished during the project has been stated elsewhere, it is a good idea to summarize the products and/or outcomes as a part of the procedures section.

6. *Evaluation.* Describe in detail the means that will be employed to determine that the project has met its objectives. These means must be adequate to carry conviction not only for the group carrying out the project, but for the funding agency as well. Areas to be covered are (1) review of objectives, (2) measurement instructions, (3) data collection procedures, (4) data analysis procedures, (5) reporting procedures, and (6) dissemination of results.

7. *Dissemination.* When funding is from federal sources, dissemination of findings is an important component. If the proposed project includes information collection and analysis, include detailed plans for such activities as publishing, attending seminars, and meetings for discussion of the project's findings. Even if your project involves services only, and no research, it is likely that periodic reports will have to be filed with the funding agency. This section will also include details on the preparation of any such reports.

8. *Budget.* Indicate the cost of the project, how much will be required from the funding source, and how much will be contributed by the applicant. Hard match (money) and in-kind (facilities, staff, equipment) contributions are required by some funding sources and not by others. Proportional or fractional requirements on hard match and in-kind contributions vary.

The budget is usually divided into such categories as (1) personnel, (2) equipment and materials, (3) travel, (4) physical plant, and (5) indirect costs.

The budget and the description of the project must agree completely. Any expenditure itemized in the budget must be reflected in the narrative, and any procedure described must be clearly identifiable in the budget.

F. LEAA Funding

Because the Law Enforcement Assistance Administration is an obvious target for rape relief programs seeking funding, it is important to know something about the organization of the agency. The LEAA was established by the Congress in 1968 for the purpose of providing funds and guidance for state and local crime prevention and reduction programs. It operates largely through a system of block grants to State Planning Agencies in all the states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and Samoa. Eighty-five percent of LEAA's funds are distributed in this way with the federal monies paying 90 percent and state funds covering 10 percent of a given program.

To become eligible for LEAA money, a state must have an approved comprehensive plan for the reduction of crime. Grants made by the state must further the objectives of the plan. Typically they deal with specialized training, personnel recruitment, and equipment for police; information systems and management techniques for courts; and community-based treatment, improved treatment programs, and personnel training in the area of corrections.

Block grant monies have been awarded to police departments, prosecutors' offices, citizen groups, and others for rape-related projects in states where the State Planning Agency has considered these efforts to be in furtherance of its plan. An organization seeking to have LEAA funds used for purposes related to the control of rape must first determine that its proposal is consistent with the state plan. If it is not, an effort can be made to remedy this problem when a new plan is drawn up. Like all government agencies, the SPA's should be responsive to public pressure.

In addition to the block grant funds, the LEAA has a much smaller amount of money for discretionary grants to innovative and specialized programs. A major area of recent LEAA interest is to make the general citizenry and the criminal justice system more mutually responsive and sensitive to their respective needs. Grants under this new discretionary program called "Citizen's Initiative" are being made for projects to aid the victims of crime, encourage witnesses to play a more active role in the effective prosecution of offenders, and promote citizen involvement in the rehabilitation of offenders. Several projects to aid rape victims have been funded by this LEAA national office in the past year.

Resources for Proposal Writers

**Annual Register of Grant Support*, Academic Media, Division of D.A.T.A., Inc., 32 Lincoln Avenue, Orange, N.J. 07050.

A Basic Guide for the Preparation and Submission of Proposals for Research Support, Western's Campus Bookstore, Western Michigan University, Kalamazoo, Mich. 49001.

The Bread Game, The Realities of Foundation Fund-Raising, Glide Publications, 330 Ellis Street, San Francisco, Calif. 94102.

The Budget of the United States Government, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Catalog of Federal Domestic Assistance, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Division of Research Grants Newsletter, National Institute of Health, NIH Building, Rockville Pike, Bethesda, Md. 20014.

The Foundation Center, 888 Seventh Ave., New York, New York 10019. Phone: (212) 489-8610. Also has a library at 1001 Connecticut Ave., N.W., Washington, D.C. 20036. Phone: (202) 331-1400. The center compiles and disseminates information and publications about philanthropic (nongovernment) foundations. Among its publications is the *Foundation Directory*.

**Foundation Directory*, Edition 5, Columbia University Press, 136 South Broadway, Irvington-on-Hudson, New York 10533.

**Foundation Grants Index*, 1970-71, Columbia University Press, 136 South Broadway, Irvington-on-Hudson, New York 10533.

Foundation News, Council on Foundations, Box 783, Old Chelsea Station, New York, New York 10011. Published every two months.

**Fundingsources Clearinghouse*, Inc.

**Grantsmanship News*, University Resources, Inc., 160 Central Park South, New York, New York 10019.

**Grantsman Quarterly Journal*, 950 6th Street, Pine City, Minn. 55063.

Guide for Non-Profit Institutions, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

How to Prepare a Research Proposal: Suggestions for Those Seeking Funds for Behavioral Science Research, by David R. Krathwohl, Syracuse University Bookstore, 303 University Press, Syracuse, New York 13210.

How to Raise Funds from Foundations, by Joseph Dermer.

How to Write Successful Foundation Presentations, by Joseph Dermer, Public Service Materials Center, 104 East 40th Street, New York, New York 10016.

A Manual for Obtaining Foundation Grants, Robert J. Corcoran Co., Fund Raising Council, 40 Court Street, Boston, Mass. 02108.

**New York Times Guide to Federal Aid for Cities and Towns*, Quadrangle Books, Inc., 300 Madison Avenue, New York, New York 10017.

**Private Foundations Reporter*, Commerce Clearinghouse, Inc., 4025 Peterson Ave., Chicago, Ill. 60646.

"Where to Get Help: The Dollars and Sense of Fund Raising," Virginia Kerr, *Ms.*, June 1973.

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*These items are quite expensive. They may be available at a local public or university library.

APPENDIX IV-F

SELECTED RESOURCE MATERIALS

SELECTED RESOURCE MATERIALS

The following listing by no means represents all the resources available in the fields of rape victim relief and rape prevention and reduction. It is intended as a cross section of materials, some books, some periodicals, some films. Most of the items on the list have been reviewed in the course of the Center for Women Policy Studies project and should be accessible to groups starting a rape intervention program from publishers, authors, and libraries. Inclusion of an item on the list does not necessarily mean Center for Women Policy Studies endorsement of the point of view of the material.

BOOKS, BIBLIOGRAPHIES:

Against Rape
Kathleen Thompson and Andra Medea
New York: Farrar, Straus and Giroux, 1974

An examination of many aspects of the crime of rape and its effect on the victim from the authors' feminist perspectives.

Bibliography on Rape
D.C. Rape Crisis Center
P.O. Box 21005
Washington, D.C. 20009

Targeted to individuals or groups involved in establishing a rape crisis center.

The Charge Is Rape
Gerald Astor
New York: Playboy Press, 1974

A presentation of the problems of rape victims, dealing heavily in anecdotal material.

Rape
Carol Horos
New Canaan, Conn.: Tobey Publishing Co., 1974

A large portion of the book is devoted to rape prevention, self-defense tactics, and household security. Includes a chapter on how to start a rape crisis center.

"Forcible Rape: Bibliography"
Duncan Chappell, Gilbert Geis, and Faith Fogarty
65 Journal of Criminal Law 248 (1974)

A 15-page bibliography targeted towards researchers. Materials classified in the following categories: Sociology, The Victim, The Offender, The Law, Medical and Medico-Legal, Police Investigation, Rape in Non-Common Law Jurisdictions.

"Rape: A Selected Bibliography"
Compiled by Katherine Ellison
New York Women Against Rape
P.O. Box 487
New York, New York 10011

Rape: How to Avoid It and What to Do If You Can't
June Bundy Csida and Joseph Csida
Chicago and London: University of Chicago Press, 1971

Written for the general reader, this book is heavily laced with anecdotal material and covers the major problems of victims as well as discussion of rape crisis centers and other efforts to assist victims.

Patterns in Forcible Rape
Menachim Amir
Chicago and London: University of Chicago Press, 1971

This study analyzes data on all cases of forcible rape listed by the police in Philadelphia for the years 1958 and 1960. It is an attempt to study the characteristics of the crime including its human and circumstantial aspects. This work is concerned with the subject matter of crime rather than with the psychology of the criminal.

Rape: Victims of Crisis
Ann Wolbert Burgess and Lynda Lytle Holmstrom
Bowie, Md.: Robert J. Brady Co., 1974

The authors' experiences in the Victim Counseling Program they established at Boston City Hospital underly the rape victim counseling approach presented in the book. The book is intended particularly for those involved in the immediate crisis situation.

Rape: The First Sourcebook for Women
Editors Noreen Connell and Cassandra Wilson
New York: Plume Books, 1974

This book is based on the premise that "The act of rape is a logical expression of the essential relationship now existing between men and women." Using summaries of consciousness raising sessions, papers delivered at the New York Radical Feminists Rape Conference, reprints and interviews, the book covers a number of issues from the feminist perspective. It includes a model rape law, medical issues, political action, self defense, and a critical bibliography.

Rape Victimology
Editor, Leroy G. Schultz
Springfield, Ill.: Charles C Thomas, 1975

An anthology exploring the perspective of professionals in psychology, sociology, medicine, and law. Includes an essay on child rape victims.

How to Say No to a Rapist and Survive
Frederic Storaska
New York: Random House, 1975

Presents techniques for escaping from or disabling a rapist. The book is closely allied with the film of the same name. Both are based on the author's presentations as a lecturer before college and university audiences.

The Politics of Rape: The Victim's Perspective
Diana E. H. Russell
New York: Stein and Day, 1975

The book grew out of interviews with over 80 rape victims. Case studies of 26 victims are presented as a format for discussion of a number of points relating to the nature of the crime of rape, its impact on victims, and the sociological conditions that foster the crime and its aftermath.

FILMS, TAPES, SCRIPTS:

"Lady Beware"
Los Angeles Police Department. Los Angeles, California

Radio series on rape
WHAS Radio
P.O. Box 1084
Louisville, Kentucky

"Rape, The Women's Crisis"
League of Women Voters
2318 N. Charles Street
Baltimore, Maryland 21218

Video tape on rape and the law
Minnesota Resource Center for Social Work Education
731 21st Avenue South
Minneapolis, Minnesota 55404

"Rape: A Preventive Inquiry"
Motorola Teleprograms
4825 N. Scott Street
Suite 26
Schiller Park, Illinois 60176

"Nobody's Victim"
Film Fair Communications
10900 Ventura Boulevard
Studio City, California 91604

"How to Say No to a Rapist and Survive"
Frederic Storaska
Learning Corporation of America
1350 Avenue of the Americas
New York, New York 10019

Handbooks, Pamphlets, Brochures, Newsletters

Counselor's Manual
Rape Crisis Center (P.O. Box 1312, Madison, Wisconsin 53701), November 1973

Freedom From Rape
Women's Crisis Center (306 N. Division Street, Ann Arbor, Michigan 48108), 1974

How to Organize a Woman's Crisis Service Center
Women's Crisis Center (306 N. Division Street, Ann Arbor, Michigan 48108), 1974

How to Start a Rape Crisis Center
Rape Center Women (P.O. Box 21005, Kalorama Street Station, Washington, D.C. 20009), August 1972

Orientation Guide for Counselors
New York Women Against Rape (P.O. Box 487, New York, New York 10011), November 1973

Rape: A Reference for Women in D.C. (prepared for distribution in public schools)
Rape Crisis Center (P.O. Box 21005, Washington, D.C. 20009)

Rape: A Problem for All Women
Los Angeles Commission on Assaults Against Women (P.O. Box 74786, Los Angeles, California 90004)

Rape: A Survey of the Care and Treatment of Rape Victims in Dallas
Dallas County National Organization for Women (Dallas Women Against Rape, P.O. Box 12701, Dallas, Texas 75225)

Rape Kit
NOW Task Force on Rape (5 South Wabash, Suite 1516, Chicago, Illinois 60603)

Rape: Medical and Legal Information
Rape Crisis Center (46 Pleasant Street, Cambridge, Massachusetts 02139)

Rape Prevention Tactics
Rape Crisis Center (P.O. Box 21005, Washington, D.C. 20009)

Stop Rape
Women Against Rape (2445 W. 8 Mile, Detroit, Michigan 48203)

Training Manual
Women Against Rape (P.O. Box 4442, Tri Village Station, Columbus, Ohio 43212)

Volunteers Handbook
Rape Crisis Service (Planned Parenthood of Rochester and Monroe County, Inc., 24 Windsor Street, Rochester, New York 14605). May 1974

We Are Women: How to Defend Ourselves Against Rape
SER-MDTA Project (4332 Maple Avenue, Dallas, Texas 75219)

Feminist Alliance Against Rape Newsletter
(P.O. Box 21033, Washington, D.C. 20009)

Lay Advocate Training Manual: A Guide to Assist Rape Victims
(Chicago Legal Action for Women, 5609 N. Broadway, Chicago, Illinois 60660)

Report of the Public Safety Committee Task Force on Rape
(District of Columbia City Council, City Hall, 14th and E Streets, N.W., Room 507, Washington, D.C.), July 9, 1973

LAW REFORM

"Findings and Recommendations for Revising California Laws Relating to Rape."
Transcript of the Hearing before the Assembly Criminal Justice Committee and the California Commission on the Status of Women (926 J Street, Room 1003 F, Sacramento, California 95814), March 1974

"Memorandum on the Prosecution of a Rape Charge."
Connie Baillie and Mary Hartle. Report prepared for the Minnesota NOW Task Force on Rape Education (NOW Task Force on Rape, 2851 E. Lake of the Isles Boulevard, Minneapolis, Minnesota 55408)

"Rape and Rape Laws: Sexism in Society and Law."
Camille B. Legrand. *California Law Review*, 61 (May 1973), pp. 919-41

"Rape and the Law in D.C.: A Victim's Guide." (Draft 2)
Rape Crisis Center Women (P.O. Box 21005, Washington, D.C. 20009), February 1973

"Rape and Victim Compensation Laws." Synopsis Draft Legislation.
Richard Wood, Chief Deputy/Legislation (Denver District Attorney's Office, Denver, Colorado), July 9, 1974

"Rights of Rape Victims." Excerpts from Testimony to the Public Safety Committee Task Force on Rape, City Council, Washington, D.C., September 18 and 19, 1973
by: Rape Crisis Center (P.O. Box 21005, Washington, D.C. 20009)

"Time for a Change in This Nation's Rape Laws."
Remarks of Hon. H. John Heinz III of Pennsylvania in the U.S. House of Representatives
Congressional Record, Thursday, May 2, 1974

"Trial of a Rape Case: An Advocate's Analysis of Corroboration, Consent and Character."
Richard A. Hibey. American Criminal Law Review, Vol. II (Winter 1973).

"The Victim in a Forcible Rape Case: A Feminist's View."
Pamela Lakes Wood. *American Criminal Law Review*, Vol. II (Winter 1973), pp. 335-354

"Judicial Attitudes Toward Rape Victims."
C. Bohmer. 57 Judicature 303 (1974)

Comment, "Corroboration and Crimes Accompanying a Rape."
118 University of Pennsylvania Law Review 458 (1970)

Comment, "The Rape Corroboration Requirement: Repeal Not Reform."
81 Yale Law Journal 1369 (1972)

Note, "Admissibility of Victim's Prior Sexual Conduct."
8 University of Georgia Law Review 973 (1974)

Note, "Prior Sexual Offenses Against a Person Other Than the Prosecutrix."
46 Tulane University Law Review 336 (1971)

Note, "Prosecution for Assault with the Intent to Commit Rape After a Prior Acquittal of Rape."
51 University of Texas Law Review 360 (1972)

The Rights of Women, An American Civil Liberties Union Handbook.
Susan Ross (New York: Avon Books, 1973), pp. 179-189

For further information on law changes, write to the legislatures in states that have reformed their laws or established investigative commissions, such as California, Iowa, Florida, New York, Connecticut, Michigan, Nebraska, New Jersey, Maryland, and Colorado.

APPENDIX IV-G

COMMUNITY ANTI-RAPE PROJECTS

April 1975

COMMUNITY ANTI-RAPE PROJECTS
April 1975

The following listing of citizen action and community projects designed to help rape victims is as complete as we have been able to make it. There are doubtless some omissions, because projects dealing with the problems of rape victims have continued to proliferate in 1975 as they did in 1974. For reasons of privacy and security, names and addresses of individuals are not included. Therefore, the list does not cover some newly formed groups still operating from individuals' homes.

The National Organization for Women (NOW) has rape task forces in almost 200 chapters around the country. Most of these chapters are not listed individually below. The National Rape Task Force coordinator for NOW is Mary Ann Largen. She can be reached through the NOW Legislative Office, 1107 National Press Building, Washington, D.C. 20004, (202) 347-2279.

ALASKA

Fairbanks Crisis Line
P.O. Box Fairbanks, Alaska
Fairbanks, Alaska 99701
(907) 452-4403

ARIZONA

Assault Crisis and Prevention Center
P.O. Box 26851
Tempe, Arizona 85282
(602) 257-8095

ARKANSAS

Rape Crisis, Inc.
P.O. Box 5181
Hillcrest Station
Little Rock, Arkansas 72205
(501) 375-5181

CALIFORNIA

Bay Area Women Against Rape
P.O. Box 240
Berkeley, California 94701
(415) 845-RAPE

Rape Information and Prevention Center
San Fernando Valley Free Clinic, Inc.
P.O. Box 368
Canoga Park, California 91303
(213) 888-6515

Women Against Sexual Abuse
12818 Morningside Avenue
Downey, California 90242
(213) 653-6333

Rape Crisis House
127 W. Main Street
El Cajon, California 92020
(714) 444-1194

Feminist Task Force
Rape Crisis Service
P.O. Box 368
Fairfield, California 94533
(707) HER-AIDE

South County Women's Center
Rape Crisis Center
c/o 25036 Hillary
Hayward, California 94544
(415) 537-2112

Marin County Rape Crisis Center
P.O. Box 823
Kentfield, California 94904
(415) 924-2100

L.A. Commission on Assaults Against Women
P.O. Box 74786
Los Angeles, California 90002
(213) 653-6333

Women Against Rape
c/o River Queen Women's Center
P.O. Box 726
Monte Rio, California 95462
(mailing address)
17140 River Road
Guerneville, California 95446
(street address)
(707) 869-0333

Mid-Peninsula WAR
c/o YWCA
4161 Alma Street
Palo Alto, California 94306

Stop Rape, Inc.
P.O. Box 651
Placentia, California 92670
(714) 525-HELP

Sacramento Women Against Rape
Sacramento Women's Center
1221 20th Street
Sacramento, California 95814
(916) 447-RAPE
(916) 442-6161 (business)

Rape Crisis Service
c/o Family Service Agency
1669 N. "E" Street
San Bernardino, California 92405
(714) 886-4889 (24-Hr.)

San Diego Rape Crisis Center
P.O. Box 16205
San Diego, California
(714) 239-RAPE

San Jose Rape Crisis Center
YWCA
375 S. 3rd Street
San Jose, California 95112
(408) 287-3000

Harbor Free Clinic
615 S. Mesa
San Pedro, California 90731
(231) 547-0202

Santa Barbara Rape Crisis Center
1220 Santa Barbara Street
Santa Barbara, California 93101
(805) 963-1696

COLORADO

Rape Counseling Service
P.O. Box 2518
Colorado Springs, Colorado 80901
(303) 471-HELP

Denver Anti-Crime Council
1313 Tremont Place, Suite 5
Denver, Colorado 80204
(303) 893-8551

Denver Coalition on Sexual Assault
227 Clayton Street
Denver, Colorado 80206
(303) 355-5510

Denver Victim Crisis Line
c/o Southeast Denver Neighborhood Services Bureau
227 Clayton Street
Denver, Colorado 80206
(303) 321-8191 (crisis)
(303) 321-1793 (office)

Rape Prevention Program
Department of Psychiatry
Denver General Hospital
8th and Cherokee
Denver, Colorado 80204
(303) 623-8252

Community Crisis and Information Center
202 Edwards Street
Fort Collins, Colorado 80521
(303) 493-3888

Pueblo Rape Crisis Center
509 Colorado Avenue
Pueblo, Colorado 81004
(303) 545-RAPE (crisis, 24-hr.)
(303) 545-8271 (business)

CONNECTICUT

People Against Rape
(P.A.R.)
448 Birch Road
Fairfield, Connecticut 06430
(203) 366-0664

Prudence Crandall Center for Women
P.O. Box 895
New Britain, Connecticut 06050
(203) 229-6939

DELAWARE

Rape Crisis Center of Wilmington
901 Washington Street
Wilmington, Delaware
(302) 658-5011

DISTRICT OF COLUMBIA

D.C. Rape Crisis Center
P.O. Box 21005
Washington, D.C. 20009
(202) 333-RAPE

Feminist Alliance Against Rape
P.O. Box 21033
Washington, D.C. 20009

FLORIDA

Rape Information and Counseling Service
P.O. Box 12888
Gainesville, Florida 32604
(904) 377-RAPE

Community Relations Commission
330 E. Bay Street
Room 406
Jacksonville. Florida 32202

Women's Rape Crisis Center
P.O. Box 10572
Jacksonville, Florida 32207
(904) 384-2234

Rape Treatment Center
Emergency Department
c/o Jackson Memorial Hospital
1611 N.W. 12 Avenue
Miami, Florida 33136
(305) 325-RAPE (hotline)
(305) 325-6901

Hillsborogh County Stop Rape, Inc.
P.O. Box 1495
Tampa, Florida 33601
(813) 228-RAPE

GEORGIA

Rape Crisis Center
Grady Memorial Hospital
Atlanta, Georgia 30303
(404) 659-1212 x4460

Carroll Crisis Intervention Center
201 Presbyterian Avenue
Carrollton, Georgia 30117
(805) 963-1696

Mayor's Commission on the Status of Women
501 Running Avenue
Fort Benning, Georgia 31905

ILLINOIS

Women's Development Council
1751 Felten, Apt. 3
Aurora, Illinois 60505
(312) 851-3675 or
897-4241

Feminist Action Coalition
Southern Illinois University
Washington Square "a"
Carbondale, Illinois 62901
(618) 536-2103

Women Against Rape
1001 S. Wright
Champaign, Illinois 61801
(217) 344-0721 (business)
(217) 384-4444 (hotline)

Chicago Coalition Against Rape
c/o ACLU
5 South Wabash, Room 1516
Chicago, Illinois 60603

Chicago Legal Action for Women
Northside Rape Crisis Line
5609 N. Broadway
Chicago, Illinois 60660
(312) 728-1920

Chicago Women Against Rape
37 S. Wabash
Loop Center, YWCA
Chicago, Illinois 60603
(312) 372-6600

Emma Goldman Women's Health Center
1317 W. Loyola
Chicago. Illinois 60626
(312) 262-8870

DuPage Women Against Rape
Box 242
Clarendon Hills, Illinois 60514
(312) 629-0170

NOW Rape Task Force
833 N. Cooper (upstairs)
Peoria, Illinois 61606
(309) 685-2346

INDIANA

Indiana University Police Department
428 N. Lansing
Indianapolis, Indiana 46205
(317) 264-7971

Women United Against Rape
(WUAR)
Indianapolis Anti-Crime Crusade
5343 N. Arlington Avenue
Indianapolis, Indiana 46226

Women's Committee on Sex Offense
P.O. Box 931
South Bend, Indiana 46624
(219) 282-2323

IOWA

Ames Hotline
Box 1150
Iowa State University
Ames, Iowa 50010
(515) 292-7000

Women's Counseling Service
310 W. 3rd Street
Davenport, Iowa 52802
(319) 322-1719

Iowa Women's Political Caucus
P.O. Box 1941
Des Moines, Iowa 50306
(515) 282-8191

Polk County Rape/Sexual Assault Care Center
700 E. University
Des Moines, Iowa 50316
(515) 262-4357 (24-hr.)
(515) 283-5666

Iowa City Rape Crisis Line
c/o Women's Center
3 East Market Street
Iowa City, Iowa 52240
(319) 338-4800

KANSAS

Lawrence Community/University of Kansas
Rape Victim Support Service
220 Strong Hall
University of Kansas
Lawrence, Kansas 66045
(913) 864-3686

Manhattan Rape Crisis Center
Kansas State University
Center for Student Development
Holtz Hall
Manhattan, Kansas 66506
(913) 532-6432

KENTUCKY

Rape Relief Center
c/o YWCA
604 S. 3rd Street
Louisville, Kentucky 40202
(502) 585-2331

LOUISIANA

Rape Crisis Center of Baton Rouge, Inc.
P.O. Box 65037
Baton Rouge, Louisiana 70806
(504) 383-7273
(504) 383-RAPE

YWCA Rape Crisis Service
3433 Tulane Avenue
New Orleans, Louisiana 70119
(504) 488-2693

MARYLAND

Rape Action Center, Baltimore County
Sheppard Pratt Hospital
6501 North Charles Street
Windy Brae, Room 103
Baltimore, Maryland 21204

University Women's Crisis Hotline
Health Center
University of Maryland
College Park, Maryland 20742
(301) 454-4616 or 4617

Montgomery County Sexual Offenses Committee
Commission for Women
64 Courthouse Square
Room 5
Rockville, Maryland 20850

Passage Crisis Center
Montgomery County Health Dept.
8500 Colesville Road
Silver Spring, Maryland 20910
(201) 589-8610

MASSACHUSETTS

Rape Crisis Intervention Team
Beth Israel Hospital
330 Brookline Avenue
Boston, Massachusetts 02215
(617) 734-4400 x2179

Boston Area Rape Crisis Center
c/o Women's Center
46 Pleasant Street
Cambridge, Massachusetts 02139
(617) 492-RAPE

Springfield Rape Crisis Center, Inc.
292 Worthington Street, Room 215
Springfield, Massachusetts 01103
(413) 737-RAPE

MICHIGAN

Women's Crisis Center
306 N. Division Street
Ann Arbor, Michigan 48108
(313) 994-9100

Women's Alternatives Crisis Center
203 15th Street
Bay City, Michigan 48706
(517) 892-1551

Detroit Rape Crisis Line
P.O. Box 35271
7 Oaks Station
Detroit, Michigan 48235
(313) 872-RAPE

Women Against Rape
2445 W. 8 Mile
Detroit, Michigan 48203
(313) 892-7161

Rape Crisis Team
Box 6161, Station C
Grand Rapids, Michigan 49506

Copper County NOW
Rape Task Force
943 Summit Street
Hancock, Michigan 49930

MINNESOTA

Rape Counseling Center
Neighborhood Involvement Program
2617 Hennepin Avenue
Minneapolis, Minnesota 55408
(612) 374-4357

NOW Task Force on Rape
2851 E. Lake of the Isles Blvd.
Minneapolis, Minnesota 55408
(612) 825-5080

Center for Rational Living
2130 Fairways Lane
Roseville, Minnesota 55113
(612) 631-2046

Family Tree
1599 Selby Avenue
St. Paul, Minnesota 55104
(612) 645-0478

Sex Offense Services Committee
c/o Department of Social Work
St. Paul-Ramsey Hospital
St. Paul, Minnesota 55101
(612) 222-4260 x402

MISSISSIPPI

Rape Counseling Service
P.O. Box 4902
Jackson, Mississippi 39216
(601) 354-1113

Rape Crisis Center
P.O. Box 2971
University City, Mississippi 63160
(314) 773-1313

MISSOURI

Metropolitan Organization to Counter Sexual Assault
P.O. Box 15492
Kansas City, Missouri 64106

MONTANA

Rape Relief Program
Woman's Place
1130 W. Broadway
Missoula, Montana 59801
(406) 543-7606

NEBRASKA

Lincoln Coalition Against Rape
c/o Women's Resource Center
Room 116 Nebraska Union
University of Nebraska
Lincoln, Nebraska 68508
(402) 472-2597

NEVADA

Community Action Against Rape
1212 Casino Boulevard
Las Vegas, Nevada 89104
(702) 735-1111 (crisis)
(702) 385-0158 (office)

Rape Crisis Center
325 Flint Street
Reno, Nevada 89501
(702) 329-RAPE

NEW MEXICO

Rape Crisis Center
1824 Las Lomas N.E.
Albuquerque, New Mexico 87131
(505) 277-3393

NEW YORK

Crime Victims Service Center
Center for the Study of Social Intervention
Albert Einstein College of Medicine
Ginsburg Building, Room 3-14
Bronx, New York 10461
Contact: Yolanda Bako, Rape Prevention and Education Specialist
(212) 829-5522

Chairperson, Citizens Advisory Committee
Anti-Rape and Sexual Assault Program
YWCA
190 Franklin Street
Buffalo, New York 14202

Crisis Service
3258 Main Street
Buffalo, New York 14214

Director of Education
Planned Parenthood
210 Franklin Street
Buffalo, New York 14202
(716) 853-1771

Erie County Anti-Rape and Sexual Assault Program
95 Franklin Street, Room 1376
Buffalo, New York 14202
(716) 846-6462

Crisis Intervention Center
C.W. Post Center
Long Island University
Greenvale, New York 11548
(516) 299-2575 (all-purpose crisis hotline)
(516) 299-2578 (office)

Mayor's Task Force on Rape
52 Chambers Street, Room 112
New York, New York 10017
(212) 566-0382

National Association of Junior Leagues
825 Third Avenue
New York, New York 10022
(212) 355-4380

Rape Crisis Service
Planned Parenthood of Rochester and Monroe County, Inc.
24 Windsor Street
Rochester, New York 14605
(716) 546-2595

NOW Rape Task Force
119 Strong Avenue
Syracuse, New York 13210

NORTH CAROLINA

Chapel Hill-Carrboro Rape Crisis Center
P.O. Box 871
Chapel Hill, North Carolina 27514
(919) 967-RAPE

North Carolina Memorial Hospital
Emergency Room Rape Crisis Program
c/o Dept. of Psychiatry
School of Medicine
University of North Carolina
Chapel Hill, North Carolina 27514
(919) 966-4551

OHIO

Akron Women Against Rape
c/o Humanity House
475 W. Market Street
Akron, Ohio 44313
(216) 434-7273

Rape Crisis Center
Women Helping Women
2699 Clifton Avenue
Cincinnati, Ohio 45220
(513) 861-2959
(513) 861-8616

Rape Crisis Center
3201 Euclid Avenue
Cleveland, Ohio 44115

Victim/Witness Division of the Montgomery County Prosecutor's Office
41 N. Perry St.
Dayton, Ohio 45402
(513) 223-8085

Project Woman Rape Crisis Center
22 East Grand Avenue
Springfield, Ohio 45506
(513) 325-3707

Toledo United Against Rape
1831 W. Bancroft Street
Toledo, Ohio 43606
(419) 475-0494

OKLAHOMA

Oklahoma County YWCA Rape Crisis Center
YWCA Women's Resource Center
722 N.W. 30th
Oklahoma City, Oklahoma 73118
(405) 528-5440 (YWCA/Resource Center)
(405) 528-5508 (hotline)

OREGON

Rape Prevention Center
P.O. Box 625
370-1/2 W. 6th Street
Eugene, Oregon 97401
(503) 485-0234

Rape Relief Hotline
P.O. Box 1363
Portland, Oregon 97201
(503) 235-5333

Rape Victim Advocate Project
Multnomah County D.A.'s Office
600 County Court House
Portland, Oregon 97201
(503) 248-5059

Women's Crisis Service
Box 851
Salem, Oregon 97308
(503) 399-7722

PENNSYLVANIA

Mon Yough-Allegheny County Rape Crisis Center
810 Walnut Street
McKeesport, Pennsylvania 15132
(412) 664-0788

Center for Rape Concern
Philadelphia General Hospital
Mills Building C-16
700 Civic Center Boulevard
Philadelphia, Pennsylvania 19104
(215) 823-7966

Women Organized Against Rape
P.O. Box 17374
Philadelphia, Pennsylvania 19105
(215) 823-7997

Pittsburgh Action Against Rape (PAAR)
932 Baldwin Street (rear)
Pittsburgh, Pennsylvania 15234
(412) 678-8895 (McKeesport)
(412) 765-2731 (Pittsburgh)

Department of University Safety
Police Services
Pennsylvania State University
University Park, Pennsylvania 16802

Chester County Rape Crisis Council
P.O. Box 738
West Chester, Pennsylavnia 19380
(215) 692-RAPE

SOUTH CAROLINA

Greenville General Hospital
Greenville Hospital Systems
Mallard Street
Greenville, South Carolina 29602
(803) 242-8377

RHODE ISLAND

Committee on Criminal Sex Offenses
c/o Women's Liberation Union of Rhode Island
P.O. Box 2302
Eastside Station
Providence, Rhode Island 02906

TENNESSEE

Knoxville Rape Crisis Center
1831 Melrose Avenue, S.W.
Knoxville, Tennessee 37916
(615) 522-RAPE
(615) 522-7273

TEXAS

Austin Rape Crisis Center
P.O. Box 2247
Austin, Texas 78701
(512) 472-RAPE

Dallas Women Against Rape
P.O. Box.12701
Dallas, Texas 75225
(214) 341-9400

Women Against Rape
Box 3334
El Paso, Texas 79923
(915) 545-1500

Fort Worth/Tarrant County Task Force on Rape
512 W. 4th Street
Fort Worth, Texas 76102
(817) 338-4211

Rape Treatment, Detection, Prevention Program
City Health Department
1115 N. MacGregory, Rm. 206
Houston, Texas 77025
(713) 222-4261

San Antonio Rape Crisis Line
P.O. Box 28061
San Antonio, Texas 78228
(512) 433-1251
(512) 433-8282

VIRGINIA

Northern Virginia Hotline
P.O. Box 187
Arlington, Virginia 22210
(703) 527-4077

Roanoke Rape Crisis Center
3515 Williamson Road
Roanoke, Virginia 24012
(703) 366-6030

WASHINGTON

Renton Rape Line
1525 North 4th Street
Renton, Washington 98055
(206) 235-2315

Feminist Coordinating Council
5649 11th N.E.
Seattle, Washington 98105
(206) 325-8258

Rape Relief
4224 University Way, N.E.
Seattle, Washington 98105
(206) 632-RAPE

Sexual Assault Center
Harborview Medical Center
325 Ninth Avenue
Seattle, Washington 98104
(206) 223-3010 (nights and weekends; ask for social worker)
(206) 223-3047 (days)

WISCONSIN

Dane County Project on Rape
120 W. Mifflin Street
Madison, Wisconsin 53703
(608) 251-5440

Rape Crisis Center
P.O. Box 1312
Madison, Wisconsin 53701
(608) 251-RAPE

Wisconsin Task Force on Rape
2770 N. 44th
Milwaukee, Wisconsin 53210

Witness Support/Anti-Rape Unit
Office of the District Attorney
Room 206, Safety Building
East Milwaukee, Wisconsin 53208

CANADA

Rape Relief
1027 West Broadway
Vancouver, British Columbia
Canada V6H1E2
(604) 732-1613

Toronto Rape Crisis Centre
Box 6597
Postal Station A
Toronto, Ontario
Canada M5W1X4

AUSTRALIA

Women Against Rape
85 Johnston Street
Collingwood, Victoria
Australia 3006
419-4644

Women's House
25 Alberta Street
Sydney, New South Wales
Australia
617-325

APPENDIX V

INSTITUTING REFORMS IN THE CONTROL OF RAPE AND TREATMENT OF RAPE VICTIMS: THE EXPERIENCE OF SIX PROGRAMS

INSTITUTING REFORMS IN THE CONTROL OF RAPE AND TREATMENT OF RAPE VICTIMS: THE EXPERIENCE OF SIX PROGRAMS

This report briefly examines the experiences of six local efforts to undertake innovative and constructive approaches to reducing rape and bettering the treatment of its victims. Our emphasis here is less the reforms themselves than the factors involved in getting them underway—those which impede, as well as those which facilitate. It focuses, in short, upon the change process itself, particularly during its early stages.

This substudy, it should also be pointed out, is exploratory and its results tentative. Its aim is simply to give the reader a feel for the dynamics of rape-related reforms as we encountered them in a half-dozen communities. While these experiences strike us as being reasonably typical of other serious efforts to improve control of rape and treatment of rape victims, we make no claims to their representativeness. Nor is our information as complete or accurate as we would like it to be. Nevertheless, despite these shortcomings we trust that these six short cases histories add a useful dimension to the information and guidelines set out elsewhere in this report.

Given the absence of resources to set up projects in precise conformity with these guidelines, however, it was regarded as sufficient if the reforms examined were consistent with, if not exactly identical to, the suggested approaches expressed in the guidelines.

Resources permitted the selection of six local reform efforts for study. In two of these (Cambridge, Mass., and Pittsburgh, Pa.)[1], the institutional auspice is a citizens' group (rape crisis center). In another (Montgomery County, Maryland), the program is operated by a public agency, which serves primarily as a counselling center. A hospital and police department are taking the lead in Chapel Hill, N.C., and Boston, Mass., respectively, and in the sixth, Middlesex County, New Jersey, the Office of Criminal Justice Planning has shared major responsibility with the Prosecutor's Office.

The programs thus come within each of the four institutional areas (law enforcement, health services, prosecution, and citizen action) examined in other phases of our study. In addition, all of the programs studied constituted innovative approaches which, in general, conform to the policies and practices urged by the guidelines. And thirdly, they all were in their early, formative stage when contacted. However, in order not to limit our inquiry too strictly, we broadly interpreted this criterion to include efforts at or close to the point of original conceptualization and problem definition (such as Boston and Chapel Hill), on through to programs which were underway but still actively engaged in formulating their basic objectives (Cambridge), or seeking funds with which to expand and stablize activities being carried out on a pilot footing (Middlesex County). Thus, the substudy covered nascent activities barely 4 to 5 months in being as well as programs that had been operational for several months or, in one case, approximately a year and a half.

As previously noted, this substudy was intended to be exploratory rather than definitive; to tentatively identify issues, circumstances, and the like which agency administrators, citizens' groups, and others might usefully incorporate into their experiential base when contemplating the initiation of reforms in their own communities, but for which no claims of universal applicability, completeness, or total accuracy are made. The reasons for this conservatism are obvious: our opportunities for information gathering were far too limited, given the complex nature of the changes that we sought to record; the historical context out of which had emerged the developments we observed could only be known secondhand; and, while it is our impression that the experiences of our six programs are illustrative of those commonly encountered, they do not constitute a representative sample of these events. For these persons, the half-dozen accounts of what others have gone through may be of some benefit in tackling the numerous and difficult problems inherent in achieving innovation in their own communities.

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[1] For convenience of exposition, these projects will be designated by the name of their location during this introductory discussion.

A. Middlesex County, New Jersey

1. *Program setting*. Situated at the northern end of the New York-Philadelphia corridor, Middlesex County contains well over a half-million people and is growing rapidly, its population having increased better than 30% between 1960-1970. Principally employed in both light and heavy industries, the County's predominantly blue collar population until recently was concentrated in the older, heavily urbanized centers, such as Perth Amboy and New Brunswick. During the past two decades, suburban subdivisions have replaced must of the former farm acreage, although considerable amounts of open space remain in the County's southern sector. The County is also the site of Rutgers University (in New Brunswick).

More than a third of the population is of ethnic stock (principally Polish, Hungarian, and Italian). As of 1970, blacks made up only 5 percent of the population.

The County is comprised of 25 municipalities, none as large as 100,000 but many in the 20,000 to 30,000 range. New Brunswick, one of the larger cities, is the county seat.

2. *Rape and the criminal justice system*. Law enforcement in Middlesex County is thoroughly balkanized: the 25 municipal departments share responsibility with the County Prosecutor's Office, which, in addition to its legal staff, is comprised of more than three score investigators. Local police investigate crimes, including rapes, reported within their jurisdictions. However, in order to supplement local capabilities, the Prosecutor's Office has for the last several years assigned a female investigator with special training in rape investigations to assist local agencies at their request. The Sheriff's Department also makes available two female deputies, who, if requested by local police, function as a female presence during victim interviews.

Private hospitals in the area do not accept rape victims for treatment and private physicians are reported to be extremely reluctant to do so. Roosevelt Hospital, the County's public facility, does treat rape victims, but until recently its procedures for the collection and preservation of physical evidence were, at best, haphazard and its physicians reluctant to testify in rape cases. County and local law enforcement agencies rely on the State Police laboratory for analysis of evidence in rape cases as well as other crimes committed in the County.

Reported rapes have increased stedily in recent years, going from 45 in 1971 to 62 during 1973. Local officials believe that the actual incidence of rape in the County is far greater. With respect to the relatively few cases that are officially recorded, moreover, the response of the County's criminal justice system leaves a substantial margin for improvement. Of the 47 cases reported in 1972, for example, 21 went to the Grand Jury, which returned 14 true bills and 7 no bills. And of the 14 indictments, 7 defendants were either convicted or pled guilty. Thus, only 33% of those cases going to the Grand Jury, and a mere 14% of all reported rapes, resulted in pleas or convictions.

3. *The Office of Criminal Justice Planning*. Innovation in the County's criminal justice system is facilitated by the Office of Criminal Justice Planning. That unit is responsible for developing the County's comprehensive criminal justice plan, preparing applications for funds, and monitoring projects. The Planning Office is headed by a former probation officer with many years' experience in the County's court and corrections systems, and who previously developed and administered Middlesex's Release on Recognizance (ROR) project. The Planner is

administratively responsible to the Assignment Judge of the Superior Court, a powerful official in the County's justice system. Because of the major role played by the Planning Office in developing a variety of improvements in the County's response to rape, a short digression to review that agency's mandate, resources, and institutional environment is in order.

The Criminal Justice Planning Office's official responsibility is improvement throughout the County's criminal justice system. Thus, unlike operating agencies (police, courts, etc.) whose efforts to upgrade the performance of their colleague institutions might well be viewed as meddling, the Planning Office is supposed to identify problems in other agencies and help correct them.

At the same time, however, the Office's intervenor role is limited. It has no authority to review budgets, establish agency priorities, or determine policy. Instead, its primary function is to assist justice agencies in coping with the intricacies of the LEAA funding process, act as their advocate with the State Law Enforcement Planning Agency (SLEPA), monitor the expenditure of SLEPA funds and the performance of projects supported by them, and advise the County's Freeholders (commissioners) which projects should be funded on a permanent basis or dropped.

Most criminal justice agencies in the county have, at one time or another, sought the Planning Office's assistance. But they are under no compulsion to do so and can approach SLEPA directly. On one or two occasions local police in fact have by-passed the Planning Office in this manner. However, the Office's track record in bringing in grants is good; cooperating agencies can avoid most of the paperwork required; and even if an agency obtains a project solely through its own efforts, the Office is charged with monitoring it. There are, in short, incentives to cooperate which in turn give the Office some leverage with individual justice agencies.

The Planning Office's influence as a change agent is also shaped by the personal qualities of the incumbent Criminal Justice Planner. Although not formally trained as a planner, and without professional training and experience in criminal justice work other than probation and bail reform, he has acquired through experience, perspicacity, and industry a sound sense of the justice system's workings. No less important, he is well known and respected for his competence and integrity throughout the County's system of justice.

Finally, the fact that the Office of Criminal Justice Planning is a component of the County court system also defines the nature and scope of its influence. To the extent that the Planning Office is able to mobilize the judiciary, it can expect powerful support. On issues of peripheral concern to the bench, on the other hand, the Office has to look to other means. Moreover, some techniques for effecting reform, notably legislative lobbying, are ruled out by reason of the Office's ties to the court system.

4. *Origins*. In the winter of 1973-74, representatives of the local chapter of the National Organization for Women (NOW) approached the Sheriff to complain of insensitive treatment received by rape victims during the course of investigations, and to urge remedial action. The Sheriff passed on their comments to the Criminal Justice Planner.

On looking into the matter, the Planner discovered that local police lacked specialized training in rape investigations, 24 of the 25 departments were staffed exclusively by male officers (one agency had one policewoman), and that evidence of insensitive questioning of rape victims abounded. The Criminal Justice Planner also discovered other problems. The County possessed no central "mug shot," physical attributes, or modus operandi files of sex offenders. Information on known rapists and other sex offenders was dispersed among the investigators in the 25 local departments and Prosecutor's Office. Moreover, many of the local agencies were not making use of the trained female investigator available through the Prosecutor's Office.

He also found that local departments often took six months or more to complete their investigations and submit rape cases for prosecution; that hospital facilities for treating and examining victims and for collecting physical evidence were deficient; that court processing of rapes often dragged on interminably, such delays contributing to witness problems and low conviction rates; and that counselling and similar services for victims were lacking.

5. *Alliance with the Prosecutor*. Early in his investigation, the Criminal Justice Planner turned to the Prosecutor's Office for assistance. He found a willing ally, prepared not only to facilitate the assemblage of information on the County's rape problem but one who shared his commitment to effecting improvement. The Prosecutor, elected on a reform platform and personally sympathetic to the objective of improving the County's handling of rape cases, was too busy to give much help himself. He did, however, assign one of his most experienced and capable Assistant Prosecutors, a woman, to work with the Planner.

By establishing an alliance with the County Prosecutor, the Criminal Justice Planner realized three benefits: he augmented his own considerable familiarity with the County's justice system with the specialized knowledge and talents of the Assistant Prosecutor; he identified himself with the County's chief law enforcement official and his office, thereby enhancing the prospect that recommended changes in handling rape cases would be accepted by the County's law enforcement community; and he insured the commitment of the Prosecutor to carrying out reforms both within his own Office operations and in other related segments of the County's justice system. He also obtained invaluable assistance in designing the strategy for reform and in carrying out a variety of maneuvers by which to implement it in the months ahead.

6. *The program plan and its development*. By Spring of 1974, the Criminal Justice Planning Office, with the active assistance of the Prosecutor's Office, had developed both a baseline of information regarding the County's rape problem and the outlines of a remedial program. Letters had been sent to the judiciary, the municipal police departments, and to various health and mental health facilities describing the need to upgrade the County's handling of rape cases, requesting their cooperation, and soliciting advice and information. In the case of the County's Police Academy, Roosevelt Hospital (the County facility), the NOW Chapter and other agencies or groups whose cooperation was regarded as particularly important, followup meetings were held to discuss in detail the problems that existed and the steps that could be taken to remedy them. Moreover, in several instances these exploratory conferences evolved into the design and implementation of corrective actions (described in a following section).

Throughout this series of contacts, the Criminal Justice Planner's approach was to function as a facilitator, assisting administrators to discover for themselves the salient information and to define the relevant aspects of the problem in ways which encouraged practical solution—and their continued participation in the planning process. In particular, the Planner attempted to frame the issues in terms that could reasonably be dealt with within institutional constraints which those officials took for granted. Improving police sensitivity to the rape victim's plight, for example, was formulated as a question of what kind of refresher training investigators (male) should receive rather than as a problem the solution to which might require the hiring of female officers.

Although the Planner and his staff bore the major burden of soliciting information and recommendations, and working through the program's design, the Prosecutor's Office assisted in several important ways. For example, the Prosecutor made explicit his commitment to the program by hiring a second female prosecutor to assist in the processing of rape cases. In addition, he and his staff participated directly in the planning of the rape investigation seminar (conducted by the County Police Academy), and in the development (in cooperation with Roosevelt Hospital's Superintendent) of improved protocol for the treatment of rape victims and collection and preservation of evidence.

The outcome of these collaborative efforts was a plan for a comprehensive program intended to mitigate a variety of shortcomings in the County's handling of rape cases and treatment of rape victims. The original plan called for the creation of a new organization (described as the "Women's Survival Center"), which would be aligned with the criminal justice system, and possess five major functions:

- Provision of counselling and information services to rape victims and their families;
- Education of police officers to the problems of rape victims;
- Publication of information respecting the unit's services;
- Coordination of the flow of information on rape cases between the municipal police departments and the Prosecutor's Office; and
- Maintenance of a 24-hour telephone service for rape victims.

The Survival Center was expected to operate in conjunction with the County's law enforcement, health, and prosecution services, each of which would institute new procedures. Thus, the County Sheriff's Office would supply women deputies to accompany victims to the hospital and otherwise serve as a female presence; the Prosecutor would employ a second female investigator to assist local police and to prepare rape cases for presentation to the Grand Jury; the County Training Academy would train the female investigator, the female Sheriff's officer, and municipal police; and Roosevelt Hospital would revise its protocol for the treatment of rape victims and collection of physical evidence.

Subsequent amendments expanded the Survival Center's clientele to include male victims of sexual assault (causing a change in title to "Rape Crisis Intervention Center"), replaced its volunteer staffing with paid professionals, and lodged the Center for purposes of administration within the Prosecutor's Office (and still later, within the Social Services unit of Roosevelt Hospital). A mental health center has been added to the roster of participating agencies, the Center's counselling and public information functions have been broadened, and a number of other modifications of a similar nature have been made to strengthen the program. The basic approach envisioned in the program plan developed during the Spring of 1974 has remained in tact to this writing, however.

Having launched this participatory process of problem solving, the Criminal Justice Planner then moved to implement two interlocking strategies. One of these, which would take many months to realize, was to raise the funds with which to convert the program into a viable demonstration project. The other, more readily within reach, was to encourage the participating institutions to institute a series of pilot reforms thereby laying the organization and programmatic groundwork for the eventual demonstration.

7. *The search for funds*. The Planner's first step in seeking funds was to send off a short concept letter (in early 1974) to the State Law Enforcement Planning Agency describing the County's rape problems and outlining Middlesex County's proposed approach. His purpose was not to request funds (he knew that none were budgeted), but instead to alert SLEPA to the need to modify the state's Comprehensive Criminal Justice Plan to permit the funding of rape projects the following year. As the Planner anticipated, SLEPA staff recognized the merits of the County's preliminary plan and adopted its ideas in revising the following year's State Plan.

In January 1975, approximately 12 months after sending in the concept letter (and after the State Plan had been revised), the Planner submitted a longer, more detailed letter reiterating a description of the proposed project, describing interim accomplishments, but still requesting no funds. SLEPA's reply gave approval in principle to the County's efforts. More importantly, it indicated that funds had been budgeted to support several rape projects throughout the state designed along the same lines as Middlesex County's. At the time of our last contact, the Planning Office was readying its formal application for submission by mid-April and had received unofficial assurance that it would be approved by approximately June 1975. Funding is expected by the following August.

The Planner, in the meanwhile, explored alternative sources of funding, notably from the Discretionary Program of the National Office of LEAA. His task appeared to be eased by LEAA's establishment in the Spring of 1974 of a special $3,000,000 program to support innovative projects for victims, witnesses, and jurors. Not only were funds budgeted, but the program's announcement described a highly advantageous timetable: grants would be awarded nearly a year sooner than would the SLEPA block grant.

Unfortunately, no such benign result materialized. In contrast to its local effort, the Planning Office was not in the position of applying to a funding source which had already accepted its suggestion for new policy; instead it was merely one of many faceless competitors for dollars which were so limited as to guarantee failure for the great majority. Moreover, the Planner and his staff had minimal experience (unsuccessful) in seeking national discretionary funds. Nor was their reputation with SLEPA for integrity and competence helpful; they were totally unknown to the National LEAA staff.

Recognizing these weaknesses, the Planning Office sought the assistance of the Center for Women Policy Studies regarding its submission in the national competition. Although itself an LEAA grantee, the Center was unable to successfully advance Middlesex County's cause, and its application was rejected. As indicated, however, the County's principal effort has been to obtain block grant funds, and in this it appears to have succeeded.

8. *Implementation*. The most remarkable feature of Middlesex County's program, however, is the large number of significant improvements which have been effected without so much as a penny of new LEAA funding. In part this was a logical outgrowth of the Planner's strategy of participatory planning: in the process of looking into the rape problem and discovering various shortcomings in their procedures, agency personnel also acquired both insight into, and commitment to, their correction. And where the needed changes involved no great investment of effort, required minimal outlays, and were plainly consistent with professional standards, it was only a short step to their implementation.

Two other factors also were at work. One was the Planner's awareness of the potency of local initiative as an inducement to funding agencies, which led him to encourage remedial action as promptly as practical. The other was the Prosecutor's wish to correct a deplorable prosecution record; as in many communities, rape has become a significant political issue in Middlesex County and one which could scarcely be avoided in the next election. He therefore took the lead in instituting reforms both within his own office and in his larger role of principal law enforcement official in the area, in cognate institutions as well. These several inducements resulted in the introduction of a comprehensive, integrated array of improvements:

- The Prosecutor has promulgated a memorandum to the municipal police departments requesting prompt submission of rape cases to his Office, alerting them to the availability of female investigators to assist in such cases, notifying them of improvements at Roosevelt Hospital, and indicating that centralized files on sex offenders are in preparation. Fewer delays and increased use of the female investigators by local police are reported.
- Roosevelt Hospital, as previously noted, has instituted new protocols for examining and treating rape victims, and for the collection, recording and preservation of physical evidence in rape cases. Police and

prosecutors are reported to be greatly pleased by these changes.

- Roosevelt Hospital has established a permanently available bed for rape victims who may require inpatient care. Further, the hospital's Crisis Clinic has retrained its entire staff in techniques for treating rape victims and has designated two staff members to provide followup counselling, including long-term therapy, if needed. (Another mental health center not associated with Roosevelt Hospital also now accepts rape victims.)
- Thee Prosecutor's Office has instituted improved record keeping procedures and is working on the creation of centralized files of sex offenders (MO, photos, physical characteristics, and nicknames) to be available to its own investigators, local police, and the Sheriff's Office.
- The Police Academy, with the assistance of the Prosecutor's staff, conducted a three-day seminar on rape investigations. Approximately 75 police officers from throughout the County attended, each local department sending at least one investigator.
- The Criminal Justice Planning Office has hired two staff members to function as the core staff of the Rape Crisis Intervention Center. Funds available under Title II of the Concentrated Employment and Training Act (CETA) were used for this purpose.

Preparation of many of these innovations was well underway by the late Spring of 1974. [illegible], January of the following year, when the Planner submitted his second concept letter to SLEPA, he was able to list them all (with the exception of the two CETA positions, which had been funded but not filled until the following month) as "activities completed." Thus, Middlesex County has initiated all of the basic elements of its program nearly a half year before the receipt of LEAA funds.

It is not to detract from the impressive roster of accomplishments to note that law reform is not one of them. At this writing, several bills are pending in the New Jersey legislature which, if enacted, will alter the administration of justice's response to rape and the treatment of its victims in Middlesex County as elsewhere in the state. Mindful of his obligations as a staff member of the County's court system, however, the Criminal Justice Planner has avoided any activities which could be construed as lobbying either for or against these bills.

Another area which the County has largely avoided thus far has been the involvement of citizens in any aspect of the planning process. This is the more conspicuous given the early role of the local NOW chapter. However, after overtures by the Planner and the Assistant Prosecutor were met with vociferous and militantly feminist rebuke, it was decided that no real cooperation either could be obtained or was, in fact, even needed. Vastly more important to their collective strategy in those early days was the marshalling of support within the criminal justice system. Collaboration with outside organizations could contribute nothing to this objective and, conceivably, might even jeopardize it. Therefore, communication with women's organization was suspended, at least temporarily. By mid-Spring of 1975, however, discussions had opened between the new staff of the Rape Crisis Intervention Center and the NOW chapter, as well as other local women's organizations.

During this same period, as the program became increasingly operational, the role of the Office of Criminal Justice Planning diminished. It will, of course, retain responsibility for monitoring and evaluating the project. But at the time of our final contact, the Office was in the process of transferring its administrative oversight of the Rape Crisis Intervention Center and other Program Components to Roosevelt Hospital's Crisis Center.

The Middlesex County program illustrates the tactics that a criminal justice planning agency successfully employed to pull together into a comprehensive, integrated plan of action a disparate group of law enforcement, prosecutor and health services agencies. The next section examines the efforts of a single institution, a large police department, to introduce improvements in its handling of rape cases.

B. Boston, Massachusetts

1. *Program setting*. In the early Spring of 1974 the Boston Police Department constituted an amalgam of the old and the new. But most important, it was an institution grappling with change.

Two years earlier, the city's activist mayor had appointed a Commissioner of Police with a reputation for having effectively reformed an inefficient and corrupt police department in the mid-west, and had given him a free hand to accomplish the same goal in his new job. The Commissioner had moved aggressively. Within the brief time he had been in office, a number of substantial changes already had taken place: lines of authority had been reshuffled to reduce the powers of the district commanders and to increase their accountability to the Commissioner and his handpicked headquarters staff, and personnel assigned to street duty had been substantially increased and their mobility and communications equipment improved. In addition, a number of corrupt officers had been weeded out or disciplined; patrol response time had been shortened and a serious problem of unanswered calls eliminated; and a variety of wasteful practices had been reduced or done away with. In short, the Commissioner had introduced into the department not only a number of discrete changes but also an attitude, a frame of mind, which was skeptical of the status quo and prepared to challenge it.

But this perspective was scarely shared by the Department as a whole. Throughout all echelons there was a sense of dismay at the Commissioner's assault on longstanding practices; he was resented also as an outsider who had never been a member of the Department, much less worked his way to the top. And in the case of those officers whose authority, perquisites, and in some cases, opportunites for illicit gain, were curtailed, the hostility was intense.

Chief among the Commissioner's opponents, however, was the Boston Police Patrolmen's Association (BPPA). Highly militant, the BPPA had demonstrated both skill and tenacity in combatting changes perceived as threatening either to its own security or the individual interests of its members. Several years earlier the union, through adroit collective bargaining, won the right to grieve over almost any change in Departmental policy. It had not been reluctant to exercise that right, having filed hundreds of grievances with the city's labor relations department. Another tactic, one which the BPPA had used more frequently than all other city departments combined, was to sue in court. And finally, on numerous occasions the union had used its influence with the City Council to override the Mayor, and thus the Commissioner.

Although ultimately failing on a number of issues, the BPPA's combative approach had forced the Commissioner to consider with care every proposed policy innovation in light of the union's expected action. It had, moreover, contributed to the creation of an atmosphere of distrust and suspicion in which nearly every innovation was converted into a labor-management dispute. Thus, for the Department (which one scholar recently characterized as being recognized by many police experts in the Federal government and in private foundations "as one of the worst . . . in the nation"[2]), reform had been accompanied by heavy costs.

2. *Initial steps and the role of the Planning and Research Division*. One of the new Commissioner's first actions was to introduce a variety of organizational changes designed to strengthen

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[2] Rory Judd Albert, *A Time for Reform: A Case Study of the Interaction between the Commissioner of the Boston Police Department and the Boston Police Patrolmen's Association*, Technical Report No. 11-75 "Innovative Resource Planning in Urban Public Safety Systems," National Science Foundation Grant G138-004, Division of Advanced Productivity, Research, and Technology, Operations Research Center, Massachusetts Institute of Technology, Cambridge, Massachusetts (January 1975), p. 2.

the decision-making capabilities of his headquarters' staff. Among these was the creation of a new unit, the Planning and Research Section, to be directly accountable to the Commissioner.

The Section's director, a civilian with a background in criminal justice planning, was one of a small group of trusted aides whom the Commissioner brought into the Department and assigned major responsibilities. Originally in charge of formulating plans and procedures for all phases of the Department's operations and structural reorganization, he increasingly devoted his efforts to securing LEAA funds with which to finance many of the Department's new programs. By April of 1974, at the time of our initial contact, the unit had a staff of over a dozen, made up of both civilians and sworn personnel. During one of the Department's recurrent reorganizations, the Section had been converted to Division status. Although this change nominally required the Director to report to the Commissioner through the superintendent-in-chief, he retained his position in the Commissioner's inner circle of aides.

In the Spring of 1974, the Department's blueprint for change did not contemplate innovations expressly intended to improve the processing of rape cases. Indeed, during an interview with a reporter, the Commissioner had indicated that in comparison with other crimes, rape was not of great importance and that improvements in other areas of the Department's operations were of higher priority.

The Director of the Planning and Research Division was not deterred by this remark. Instead, he was of a mind that the Commissioner had spoken without having had a chance to review the relevant facts and without giving sufficient attention to the pressures for improvement in the treatment of rape victims which was then building up in the community. (For an account of these developments, see the case history of the Cambridge program.) In particular, the Director was confident that if provided with a well-conceived plan of action, adequately documented and cogently presented, the Commissioner would change his mind. On his own initiative, therefore, he had instructed one of his staff to conduct a preliminary study of the city's rape problem as a first step toward preparing such a document.

A short digression to compare this situation with that of Middlesex County may be useful at this point. There are, of course, several obvious parallels. The duties of the Planning and Research Division and the Middlesex Criminal Justice Planning Office, for example, were similar. Both were mandated to facilitate improvements throughout their respective institutional settings and both were charged with procuring the funds to finance such innovations.

The Planning and Research Division's Director, like the Middlesex Planner, possessed appropriate experience, having been in charge of publications at the International Association of Chiefs of Police and thereafter a deputy to the Director of the Police Foundation. Moreover, because of his close ties to the Commissioner, he had access to influence comparable to that which the Middlesex Planner derived through his alliance with the Prosecutor.

At the same time, the two situations also differed in significant ways. The Middlesex Planner and Prosecutor saw eye-to-eye on the need to upgrade the County's handling of rape cases: for both, it was in their institutional self-interest to do so and to collaborate to that end.

In Boston, however, the Police Commissioner was struggling to push through a host of major reforms in an agency which many observers regarded as obsolete, inefficient and corrupt, and over the skilled opposition of a powerful union. Under these circumstances, his reluctance to give innovation in the processing of rape cases a high priority was altogether understandable. Yet this is just what the Director of Planning and Research proposed should be done, thus necessitating a conversion of the Commissioner to his point of view if he was to benefit from that source of influence.

In addition, the Department's internal turmoil was far different from the mutual accommodation which generally characterized interagency relations in Middlesex County. As a result, when the Planning and Research Director had attempted participatory planning involving line staff as a technique for change he had run into strenuous union opposition.

The Planning and Research Division's study consisted of two parts: a series of basic statistics on rape derived from the Department's records and some preliminary policy recommendations. Much additional work remained. The statistical data had neither been analyzed nor were they integrated into the provisional policies. Indeed, the latter had been developed on the basis of altogether different information having to do with deficiencies in the medical examination of victims and in the Department's own investigative practices. This information, however, had not been assembled or analyzed, nor had alternative policy implications been explored.

At the request of the Planning and Research Director, we assisted his staff in conducting a further study and in preparing a memorandum of findings and recommendations.

The paper consisted of three parts: (1) the statistical characteristics of reported rape in Boston and their implications for agency operations and further study; (2) an overview of the city's criminal justice system's processing of rape cases and treatment of rape victims, focusing on the Department's own operations; and (3) a series of recommended changes.

In reviewing the Department's response to rape, a number of serious deficiencies were provisionally identified. These ranged from insensitive treatment of victims, particularly by patrol officers, to insufficient communication and information sharing between patrol and investigation and between districts, nonexistent crime analysis, failure to develop proper procedures for the collection and preservation of evidence by hospital staffs, the lack of a centralized and easily accessible modus operandi file, and defective records systems. To deal with these and similar problems, the memorandum proposed two "threshhold" changes which could be implemented relatively easily, quickly, and inexpensively. It also set out three additional programs, each of which would build upon the threshhold innovations to produce comprehensive changes in the Department's capacity to cope with rape and deal humanely with rape victims.

The two areas in which the memo urged that the Department move with dispatch were: (1) creation of a small new unit (or subunit of the Planning and Research Division) to undertake further study, planning and evaluation, thereby continuing and expanding the abbreviated efforts made to date; and (2) provision of appropriate training for the Department's investigators, patrol force and recruits, based upon recent research findings in the areas of crisis intervention and rape victimology. The memorandum argued that, by themselves, these two innovations would be unlikely to substantially improve the Department's response to rape and its victims. Their utility, it was suggested, would be to initiate a process of gradual change, to constitute the first steps toward more fundamental innovations dealing with basic flaws in the Department's structure and operations affecting rape investigations and related matters.

The three optional programs, each of which consisted of comprehensive but integrated modifications in Departmental organization, procedures and training, completed the recommendations. The memorandum noted that their value would depend on the degree to which one or more were capable of being linked with other major reforms underway within the Department. The summer passed, with no reported reaction by the Commissioner. So, quite clearly, the document had failed to alter the low priority assigned to reforming rape-related practices and policy.

3. *The Rotenberg Bill and related developments*. But if the impetus for change had dissipated within the Department, in the community it had acquired a new momentum. In

part, this occurred as the result of two highly publicized court decisions that focused public attention on the crime of rape and the justice system's response to it. In late spring, a Boston jury voted for acquittal under circumstances which caused the male judge to openly criticize its decision. And later in the summer another trial resulted in a conviction of multiple offenses and the imposition of three life sentences. Ultimately of far greater impact, however, was the enactment of the Rottenberg Bill.

This legislation had been lobbied aggressively by various feminist groups, but was largely unknown to law enforcement interests. Taking effect in July 1974 the statute (officially designated as Chapter 581, Acts of 1974, M.G.A.) mandated the creation within the police department of all towns and cities throughout the state of "a rape reporting and prosecution unit." Such units would consist of investigators who had completed a training program approved and funded by the Massachusetts Criminal Justice Training Council. Each department was required to "make efforts to employ women police officers" in such units, to establish a 24-hour special telephone exchange for the reporting of rape, and to widely publicize both the special number and the activities of its rape reporting and prosecution unit. Rape reports were to be kept confidential by police.

The Department's initial response was to downplay the significance of the new law. In a response to a request from the Director of Planning and Research for an opinion, for example, the Department's Legal Advisor indicated that compliance could be achieved "at minimum expense." He went on to note that the law established no criteria either for the size of the unit or the scope of its duties other than the vague directive that it be "designed to improve the quality of rape reporting, counselling, and prosecution."

Other loopholes were that members of the unit could continue to perform other duties; their training need be merely approved by the Training Council, which has this responsibility already; the assignment of policewomen to the unit was not required; and the Department's 911 line probably satisfied the requirement for a 24-hour special number. This interpretation ignored the bill's legislative history, which included ample testimony respecting the need for major improvements in law enforcement's treatment of rape victims. In addition, of course, he offered scant support for the comprehensive—and ultimately costly—changes which the Director of Planning and Research was then proposing.

4. *The focus shifts to the Training Division.* The Rottenberg Bill was perceived as a step in the right direction by the Boston news media. Several articles, editorials, and other commentaries appeared in the press and were carried on television and radio during the summer. As time wore on and no action by the Department to comply with the law could be detected, their tone became critical. A serious disturbance broke out in South Boston in late summer following a U.S. District Court's decision requiring busing to achieve racial integration. The Department's efforts to quell these disturbances occupied the attention of management to the exclusion of most other matters. In fact, however, despite this distraction the Department did move to comply with the law, or at least that section which required investigators to complete a training program approved by the Massachusetts' Criminal Justice Training Council.

In late September, the Police Commissioner submitted to Council a prospectus for a training program in rape investigation to be conducted in three stages: (1) the selection and training of a small group of trainers; (2) the preparation of a manual of procedure for rape investigation that would be developed as part of the trainers' training; and (3) implementation of training at in-service and recruit levels. The course would consist of a series of ten modules which all trainees would receive. However, the modules would be expanded to fill 50 hours in the case of recruit training and shortened to 24 for purposes of in-service training. The instruction would take place in groups of 20 or fewer trainees, using a seminar format. Video tapes of interviews with victims, with experienced rape investigators and of simulated investigative interviews would supplement the discussion and reading materials. In early fall of 1974 the Massachusetts Criminal Justice Training Council approved this format and with that the Department began at last to give serious consideration to improving its handling of rape investigations and treatment of rape victims.

The Department's new program was spelled out in a document (*The Handling of Rape Offenses by the Boston Police*) issued by the Planning and Research Division in October.

The training unit was headed by a civilian brought into the Department by the Commissioner. Though not placed as high up in the table of organization as the Planning and Research Division, the Training and Education Division nonetheless enjoyed high status. The Division was viewed by the Commissioner as a basic mechanism by which to introduce professional standards and practices throughout the Department. No longer accorded the low status of many such police units, the Training Division had become a center of significant influence which in turn had attracted some of the Department's better officers.

Though the Director of Training oversaw the development of the new program, its actual architect was a consultant to the Division. A professor of psychology at Boston University, the consultant had earlier developed and carried out a successful program of training Departmental personnel in family crisis intervention.

His approach was to blend his skills as a teacher/researcher with the relevant talents available within the Department and the Community. He solicited the aid of the rape crisis center located in Cambridge. The Center's representatives spent many hours helping to review and improve the training prospectus. They also recruited five rape victims willing to be videotaped as they discussed their experiences, and thereafter assisted in editing the tapes. In a similar fashion, the consultant employed an experienced investigator assigned to the Training Division to provide professional law enforcement input. The investigator in turn enlisted the assistance of a crime lab technician and a panel of other experienced detectives to develop additional tapes.

These efforts were ongoing throughout the Autumn and Winter of 1974, and on into January and February of the following year. In the meantime, however, a number of major issues remained unresolved.

5. *Creation of a comprehensive program*. The training program prospectus had been a thoughtful outline that focused on the content and methods of rape investigation and the treatment of victims within this process. Beyond vague reference to the possible creation of a specialized unit (as visualized in the Rottenberg Bill) and a proposal that it be staffed by the core group selected from "the ranks of the department" to be trained as trainers, however, it offered few specifics respecting the program's administration.

By late fall and winter of 1974, the news media had begun to hammer away at the Department (as well as other police agencies throughout the state) for its failure to establish a rape reporting and prosecution unit and other innovations specified in the Rottenberg Bill. The Department's response was to create a Headquarters Sex Crimes Unit in late February of 1975 which consisted of a senior sergeant who many years earlier had investigated several rape cases and who more recently had been in charge of the Department's rape prevention public education program. His mandate was to "coordinate" the Department's rape program, an assignment magnificent in its unblemished imprecision.

In the meantime, the consultant responsible for preparing the training program had begun to concern himself with many of these organizational and administrative issues and in March of 1975, submitted a preliminary plan for a comprehensive rape response program.

The 2-year program was to be conducted in sequential phases, and involved integration of structural reorganizations, new procedures, training, evaluation, and feedback. It recommended that in order to provide the Headquarters Unit with the authority and legitimacy needed to accomplish its objectives, it be put under the supervision of a Deputy Chief; that the Unit be given explicit authorization to undertake various administrative actions intended to facilitate improvements in rape investigations as well as to conduct on-going planning and evaluation, and to coordinate all rape-related training; that it be appropriately staffed to perform these duties; and that the Unit be organized so as to receive regular input from both Planning and Training Divisions. The plan outlined a multiphased training program beginning with an initial group of 60 patrol officers, but extending eventually to all patrol officers, investigators, phone operators and dispatchers.

Also proposed was a systematic use of community resources, particularly the hospitals and rape crisis centers in the area, and the steps for doing so. The plan recognized the importance of orientating not only command staff but also mid-echelon personnel (captains, lieutenants and sergeants) to the goals and methods of the program. And, finally, the plan spelled out a timetable by which these various steps would be accomplished.

Our case history, unfortunately, ends at this point. Beyond learning that the plan received approval in principal by the director of Training and Education, we have no knowledge of the Department's reaction. Certainly, conditions have changed appreciably since the time—more than a year ago—when the Commissioner offered the judgement that the crime of rape and the treatment of its victims was a matter of less than major importance to his agency. The community, through the enactment of the Rotenberg Bill, has reached a different conclusion. Moreover, with mayoralty elections less than half a year off, there will soon be an opportunity for those in favor of a more vigorous response by the Department to make their opinion known once again. In addition, despite delays and half-measures, there now appears to be a degree of momentum within the Department itself.

At the same time, of course, various factors remain which could slow down or drastically limit the scope of the Department's eventual program. The plan devised by the training consultant was, at our last contact, only an outline; it will require a great deal of further refinement before being capable of implementation. It involves, as well, very substantial costs for which funds will have to be procured in competition with other Departmental needs. There remains the question of the union's reaction to all or part of the program. If serious exception is taken, the result could be grievance petitions, litigation or other obstacles to implementation. And, finally, South Boston may once again explode or some other major emergency arise which would force a diversion of the Department's resources.

In any event, the Department has made substantial progress to date. And, despite these possible contingencies, it now possesses the potential to mount a program which could substantially upgrade its capacity to cope with rape and deal humanely with victims.

One innovative feature of the Boston Police Department's program has been its extensive reliance on representatives of the victim community in developing the training component. The next section discusses the citizen organization, located in Cambridge, Mass., which supplied the assistance.

C. Cambridge, Massachusetts

1. *Origins and Setting.* The Boston Area Rape Crisis Center traces its origin to a group of about 10 members of the Women's Educational Center, Cambridge, Mass., who came together in the fall of 1972 to start a project on rape. About half of the original group had themselves been raped; the others had friends or acquaintances

who had been sexually assaulted. As part of their commitment to the women's movement, the 10 shared a sense of outrage not only at the crime and those who perpetrate it, but also at the mistreatment of the victim by society thereafter. Particularly distressing was the often callous and occasionally prurient reaction of doctors, police, prosecutors, and other functionaries of the medical and legal institutions to whom victims had reported their plight and to whom they looked for support and concern.

In the Boston area, as in virtually every community at that time, a pervasive mythology surrounded the crime which not only exacerbated the suffering of its victims but which because of its incorporation within the law and its administration impeded the detection, apprehension and prosecution of rapists. Many hospitals in the region were reluctant to accept rape victims for treatment and some would refuse outright. In those facilities that did accept victims, most had minimal examination and treatment protocols, while none routinely collected physical evidence for use by police. As previously described, the practices of the Boston Police left much room for improvement yet were scarcely worse than those of other law enforcement agencies in the area. The court system in the state, should a victim persevere in her cooperation with the administration of justice to that stage, imposed still more humiliation and related burdens.

The group of 10, while hardly alone in these concerns, had few precedents to look to for guidance. Two researchers at the Boston College School of Nursing were beginning their studies at Boston City Hospital which would eventuate not only in pioneering findings but also in a pilot counseling and referral program at the Hospital and a semester-length seminar at the School of Nursing. A Rape Task Force, chaired by a representative of the City's Division of Health and Hospitals, would come into being shortly. And one of the better hospitals in the region, Beth Israel, within a year would begin to revamp its procedures for treating rape victims, but at the time was following protocols similar to those generally in use in the Boston area.

2. *Initial Activities and Issues.* The first efforts of the group were to identify the parameters of their problem with greater precision. To this end, a questionnaire was prepared and mailed to the hospitals in the region requesting detailed information regarding their policies governing the treatment of rape victims. The members interviewed hospital administrators and nurses in charge of emergency rooms. In addition, the Women's Law Collective lent assistance by looking into the law and related practices. On the basis of these investigations, the group prepared an instruction booklet for rape victims describing the salient features of the medical and legal systems in the metropolitan area and how to deal with them.

Representatives of the group visited the rape crisis center in Washington, D.C. In concept the first of its kind, the D.C. center also had been in operation a sufficient length of time to have acquired a valuable baseline of experience. It constituted a model whose basic principles the Cambridge group chose to emulate.

The Boston Area Rape Crisis Center opened its doors in March of 1973. Legally constituted as a nonprofit corporation, it was in fact to be operated as a collective whose members sought to avoid the invidious distinctions in role and status which characterize most other institutions. From the beginning the Center's primary objective has been to recognize and support the rape victim as an individual. For some of the original members this focus had as its corollary a secondary objective of fostering a radical approach to the promotion of women's rights. The others in the original membership favored a strategy of effecting change within society's institutions through the conventional means of education and training and, at a lower level of priority, lobbying and related political action.

It is reported that a great deal of time and effort was devoted to debating these issues during the spring, summer and fall of 1973. Gradually, however, the more radical members dropped out and their places were taken by less militant activists.

In addition to these struggles, the Center also encountered various operational growing pains. One difficulty was in obtaining a number for its emergency telephone whose last few digits contained letters which spelled RAPE. The Center encountered so much resistance from the phone company that it was obliged to obtain the services of an attorney–a step which solved the problem in a couple of days.

A far more serious matter was the insufficient number of volunteers to staff the phone. At first the Center simply allowed calls to go unanswered during the hours volunteers could not be present. Thereafter for 4 to 6 months it experimented with a tape recorded answering device. This too was thoroughly unsatisfactory, and at present an answering service, combined with two volunteers who are on-call, is used.

Unlike many similar ventures, however, the Boston Area Crisis Center was not hobbled from the outset by financial problems. Space is provided at low cost by the Women's Educational Center and other expenses, such as telephone and answering service, are met by donations, speaking fees, and poster sales.

Our first contact with the Center occurred in mid-summer of 1974. By that time, its operations had to a great extent shaken down; and despite several remaining basis policy issues, its goals and methods had become largely stabilized. The remaining discussion reports the Center's organization and operations as they were found to exist during the fall and winter of 1974.

3. *The Center's Membership and Organization.* The Center's core of volunteer staff has slowly grown, presently numbering between 15 to 17. All are white, middle class, and range in age from 18 to 45, although most are in their twenties. Nearly half are college or graduate school students and most of the rest are employed, principally in professional, service, or clerical work. As indicated, this core group is very much oriented to the principles of the women's movement, but although militantly feminist is not radical in outlook. There also is a marginal group, numbering about 15 to 20 women, who share these same characteristics but whose involvement in the Center's activities is relatively limited, either because they are in the area only during the academic year or because they prefer to restrict their participation.

The Center's current policy is to maintain its membership at about these levels. To make up for membership attrition (due mainly to volunteers leaving the area), however, it also recruits candidates from time to time. Recruiting is by word of mouth and by advertising in two underground newspapers. Training is conducted by the core volunteers, runs four weeks, and consists of two-hour weekly meetings. During these sessions the participants exchange experiences and engage in simulated exercises to become familiar with the kinds of problems they will encounter in their volunteer work. The trainees are oriented to the Center's goals, style of operation, organization and functions. Particular emphasis is given to developing the counselling skills needed to assist rape victims. In addition, on-the-job instruction continues for those who complete the training. However, the drop-out rate for trainees runs about 50 percent. Some decide to leave because they fail to realize the large amount of time they would be required to put in or because they are only interested in certain aspects of the Center's work and thus are not willing to accept its collectivist orientation. And a few drop out because they find the Center's politics either too extreme or insufficiently radical.

Each volunteer is expected to spend a minimum of 20 hours a week on the Center's activities. About 4 to 6 hours are spent in covering the emergency phone. In addition, once a week every volunteer puts in an eight hour stint from 11:00 p.m. to 7:00 a.m., during which time she is on call and responsible for responding to calls delayed by the answering service. There also are weekly business meetings during which all decisions are made, and which all core members are expected to attend. The volunteers take turns chairing these sessions. Decisions are arrived at through a process of discussion until consensus is reached. The balance of a member's time is taken up by other tasks, such as counselling, public speaking, training police officers, and so forth. Assignments are worked out at the weekly meetings.

4. *Operations.* Highest priority is given to assisting women who have been raped to deal with their crisis reaction to the assault, and with the attendant psychological and physical trauma, family disruption, impositions created by the criminal justice process, and so forth. Second priority is public education, which the Center's members describe as consisting of two kinds: public speaking before interested groups and working with police, hospitals, and other such institutions to increase their sensitivity to the plight of rape victims. Third, and last, the Center is prepared to engage in political action to effect reforms on behalf of rape victims.

Victims are aided through several measures. There is, as mentioned, the emergency phone number that is staffed 24 hours a day, including the answering service/on-call system used during the night.[3]

The great majority of callers are victims who (1) were raped more than 48 hours prior to contacting the Center (in a few cases, as long ago as 8 to 10 years) and (2) have not reported to the police. The Center's volunteers provide callers with medical and legal information if needed, counselling, and information about the Center and its services.

The Center also offers crisis counselling for those who need this relatively intense assistance, and long-term, follow-up support for as long as it is desired. No other program in the region provides long-term assistance, even though a substantial number of victims experience severe stress on the anniversary of their attack, at the time of trial, and on other occasions long after the event. Victims who require professional assistance are referred to mental health clinics, but even in those cases the Center will remain in touch if the client so requests. Each volunteer is responsible for her own caseload (which may vary in number from 3 to 4 to 20 or more), but in addition victims are encouraged to attend semi-monthly discussion groups as way of keeping in touch with others with similar experiences. The Center has found that some women are offended by feminist militancy and therefore involves victims in political discussions only to the extent that they are interested. In addition to counselling, the Center assists victims by accompanying them to interviews with the police or prosecution, and to court hearings.

The Center's public education program consists of speaking engagements at high school classes on sexuality, women's organizations, professional groups (including seminars at the Harvard Medical School and Yale University), television programs, and so forth. For the most part these have been in response to requests. More appearances would help to inform more victims and could be generated by solicitation, the Center believes. However, this is avoided in order not to further strain the volunteer's limited time. The Center also distributes copies of the booklet on legal and medical information prepared during its first months of operation.

The second phase of the Center's public education program has involved the development of remarkably close working relationships with the Cambridge and Boston Police Departments' training programs. The Center's volunteers first contacted the Sargeant in charge of the Cambridge unit responsible for investigating rapes and other major crimes. Their intention was to find out how police went about investigating rapes, the procedures involved, the questions asked, and so forth in order to learn what if anything the Center could do for victims during the investigative process. This inquiry led them to the Captain in charge of the Department's training academy, which was then at the point of developing an ongoing, inservice training course for all officers in the Department. The Captain was favorably impressed by the Center's volunteers and invited them to participate in an inservice training session. Their successful handling of that session led to their regular participation in all the Department's inservice training cycles from March through November of 1974.

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[3] Between March 1973 and December 1974, the Center's records indicate that it received 1880 calls, of which about 1100 were from different individuals. Approximately 300 callers had been assaulted within 48 hours of calling. Of these, it is estimated that 2/3 involved actual raped; the others were attempted rape.

As a by-product of this assistance, the Center has developed a good relationship with many of the Cambridge police officers. The Center's volunteers drop in at Headquarters to provide third person reports, to look through mug shots, and to compare notes with detectives. Similarly, the information about police work, which the Center's volunteers have picked up, enables them to better orient victims to the kinds of questions to expect during interviews and to other steps in the law enforcement process.

The Center has not, at this writing, developed as extensive a relationship with the Boston Police. As described elsewhere, however, two volunteers contributed invaluable assistance to the Boston Police Training Division in preparing its rape-related training. They reviewed and criticized the consultant's prospectus, recruited five victims willing to discuss their experiences while being taped, and assisted in the editing of those tapes. Moreover, should the training consultant's plan be adopted, the Center will be requested to assist in monitoring the Department's rape program and feeding back to the Department its findings.

As previously noted, the Center does not give priority to the political process, preferring to leave this activity to the other feminist groups. However, it did offer advice and information to such groups lobbying for passage of the Rotenberg Bill.

5. *Remaining Issues.* Although the Center's membership is relatively content with its current style and level of operations, several issues are likely to arise in the coming months. One of these is whether to seek additional funds. The Center, to date, has avoided major expenses by reason of its free space and modest scale of operations, and has been able to meet its other costs through speaking engagement fees, donations, and the like. Nevertheless, the Center's financial situation is tight, which not only restricts its services but requires its members to meet minor out-of-pocket expenses from their own resources. Moreover, at least some of the volunteers would like to spend a much greater proportion of their time on behalf of the Center, but lack the financial independence to do so.

One result of these pressures was that the Center entered the LEAA $3,000,000 competition for victim/witness/juror projects conducted in the spring and summer of 1974. Had it been successful, its grant would have enabled the Center to pay several volunteers on a part-time basis and to have increased the budget for printing and distribution of educational materials. Not all of the members were enthusiastic about the prospect of Federal funding, however, on the grounds that it would disrupt several aspects of the Center which these members feel are highly important: payment of some but not all members would undermine the collective structure; the necessity of complying with Governmental regulations on record maintainance, reporting, expenditures, etc., would infringe upon its authority; dependence would be encouraged; and the Center's performance would be measured against criteria with which the members might disagree. The additional dollars would mean that much was lost in return for a short-lived gain.

Closely related is the issue of whether to maintain the Center at its current membership size and scope or operation or to expand both. If services were increased, more victims could be helped. Already the Center has been asked for help by groups in other communities (including Springfield at the western end of the state), and there is ample room for increased services in and around Boston. But for services to be expanded, the number of active volunteers would also have to rise (assuming no paid staff or increase in volunteered hours), and some members are opposed to this.

Once again the fear is that certain qualities of the Center's way of operating will be lost, and, with them, much of the pleasure and satisfaction that comes from working for the Center. The present membership size enables all the volunteers to be intimately involved in all aspects of the Center, the nitty-gritty as well as the more exciting activities, and thereby enhances the sense of shared endeavor. A greater number would lead to specialization and, therefore, fragmentation. Moreover, it would tend to dilute the intensity of the members' commitment. It also would complicate the consensual process of decision-making and perhaps even fracture the membership into those who lead and those who are led.

The Center's members have thought hard about these issues and although many of them may be undecided, the arguments *pro* and *con* are well understood. This is less true of a third issue which has only begun to emerge but which may become no less critical in the near future. Thus far the Center has achieved remarkable success in developing effective working relationships with two major law enforcement agencies. It has achieved this success by employing tactics which facilitate the agency's capacity to function as that agency itself defines its role. The Center has sought to help; it has not sought to criticize.

Yet, as the Center's volunteers became familiar with the day-to-day operations of the Cambridge Police they also discovered the existence of a long-standing practice which they felt was detrimental to the interests of rape victims but which was not susceptible to improvement by inservice training. Similarly, the Center is much interested in upgrading the emergency room services for rape victims in one of Boston's most prominent hospitals. Because two of the volunteers are employed in the hospital, they are acutely aware of the many shortcomings in need of correction. A training program for emergency room personnel could be arranged, they feel. But for various cogent reasons they realize that such a program would have minimal impact and that more basic changes are needed. At our last contact with the Center, several of the members were beginning to grapple with the realization that its facilitator/educator role has limitations and that supplementary strategies for effecting institutional change may be needed. However, this analysis was still in its early stages and no policy had emerged.

D. Orange County, North Carolina

In late 1973 a psychiatrist at the North Carolina Memorial Hospital was working with representatives from the Emergency Room and the Department of Obstetrics and Gynecology to improve their treatment of sexually assaulted women. This work began as the result of adverse publicity surrounding the poor treatment of a rape victim in the emergency room. She and other members of the hospital staff were also meeting with the legal advisor to the police department to discuss how the hospital and local law enforcement agencies could collaborate to improve their response to rape victims. Some of these women were members of the local chapter of the National Organization for Women, which was counseling and otherwise assisting women who had been raped.

Consultants from the Center for Women Policy Studies first visited this group in June 1974 to discuss with them their plans for a comprehensive county-wide program for rape victims and to assist them in their efforts to find funding for their program. The following background information was collected at that time:

1. *Setting.* North Carolina Memorial Hospital is located in Chapel Hill, which is the home of the University of North Carolina and generally regarded as a pocket of liberalism in the South. Adjoining it is the town of Carrboro, which is a working class community housing a much larger percent of black people than does Chapel Hill. Hillsborough is the third incorporated town and the county seat of Orange County.

The southern part of the county is dominated by the University and Memorial Hospital, while the remainder has an agrarian base. Thus the population is an extraordinarily diverse one, encompassing students, highly trained professionals and academicians, small business people, white and blue collar workers, independent farmers, sharecroppers, and the very affluent and the very poor.

In 1973 there were 13 rapes and 26 attempted rapes reported in Chapel Hill, which has a population of 27,000, and about half as many in the adjoining town of Carrboro, which has a population of 7,000. Between November 1974 and September 1975, 15 adult and an equal number of minor rape victims were treated by the Memorial Hospital Emergency Room. Unlike in the rest of Orange County, reported rapes in Chapel Hill is mostly interracial.

This fact is an unpleasant one for the liberal population of Chapel Hill, which is well aware of the history throughout the South of limiting prosecutions for rape to cases in which black men allegedly assaulted white women. The town has a black mayor and appears to have made significant strides toward reducing racism in government including the criminal justice system.

An additional problem for the people of Chapel Hill who tend to oppose capital punishment is the fact that North Carolina is one of the five states in which a convicted rapist can still be sentenced to death. Until April 1974 rape carried a mandatory death penalty. Presumedly for this reason, it has been extremely difficult to obtain a conviction for rape in certain parts of the state.

The county is part of a tristate judicial district with the Solicitor's Office located in an adjacent county and an assistant solicitor and the court located in Hillsborough. Each town has its own law enforcement agency, the county has a Sheriff's Department, and the University has campus police.

Memorial Hospital is the teaching hospital for the University of North Carolina, the major referral center for the state and the primary health care facility for the area. There is no law in North Carolina that requires the hospital to report a felony to a law enforcement agency nor is there any law that relieves a hospital or doctor of civil liability for making such a report.

2. *Community Response to the Crime of Rape—Problem Areas.*—The hospital group was convinced that there were many more rapes committed in the county than were reported to the police and that only a small percentage of the victims came to the hospital for treatment. Through their cooperation with the NOW group, they knew that many women who called feminist volunteer counselors about rapes in the immediate or distant past had not gone to the police or hospital.

Several hypotheses were developed to explain the lack of reporting within different sectors of the population. It was believed that the affluent families affected by the crime consulted private physicians and avoided the scandal of involvement with the police. At the other end of the socio-economic scale, women were thought to be secretive about the crime out of fear of the assailant or of family members who might question her role in the event. No one was certain how rape or attempted rape was dealt with on the University campus because the University has its own health services and security force which, like the hospital and private physicians, are not legally obliged to report a felony to the Chapel Hill police. It was also surmised that the University would prefer not to report or publicize crime on the campus, rationalizing that it was not in the interest of its own reputation or that of the student to do so. Campus health service personnel who dispensed the "morning after pill" and prophylactics for venereal disease believe that some students requesting them had been raped.

Women who had not reported rapes in the past told volunteers that they were reluctant to subject themselves to what they anticipated would be callous treatment by both law enforcement and health services personnel. Another disincentive was believed to be the mandatory death penalty which made juries reluctant to convict in all but the most atrocious cases. A victim could not be expected to subject herself to the rigors of confronting her attackers in the courtroom knowing that he was likely to be acquitted and freed to, perhaps, menace her again.

The legal problem was only partially alleviated in 1974 when capital punishment for rape was limited to cases involving deadly force, serious bodily injury, or a child under twelve. The entire criminal code is being rewritten, but will not be considered for approval by the legislature for four or five years. Because it seems unlikely that the legislature will be willing to consider lowering the penalties for rape again until then, both the hospital group and the prosecutor interviewed were discouraged about the prospects of the state obtaining convictions for rape in Orange County. The NOW chapter, however, has begun to organize and lobby to change the sentencing structure.

A second problem area that the hospital group perceived was the lack of cooperation among the various agencies that might come in contact with a rape victim. The most important weak institutional link was between the hospital and the local police departments. In fact, the hospital was very chary about dealing with the police at all since information about a crime victim which medical personnel gave the police in confidence had on one occasion reached the local newspapers. Since there is no felony reporting act in North Carolina, hospital personnel arguably breach the doctor-patient privilege by giving information to law enforcement agencies.

Furthermore, the relationships among the police chiefs in Chapel Hill and Carrboro and the county Sheriff were strained. Despite the proximity of their respective jurisdictions, there appeared to be no formal working relationship at the highest level.

The prosecutor felt his hands were all but tied with respect to sexual assault cases because of the law, particularly the high penalties which have already been discussed. Furthermore, he felt that police investigation was poor and made his job difficult at times.

In the citizen sector, the NOW chapter, which had confronted the Chapel Hill police with respect to their response to rape and rape victims, was initially considered an adversary of law enforcement agencies. Although they were meeting and planning with the hospital group when the Center consultants first visited the site, a split later occurred between the two and it seemed they were setting up competing services. After the Center's formal monitoring process ended, a new person took over the NOW task force and developed a good relationship with the hospital group. Several joint projects are now underway, including training of police officers.

A third problem area which had been identified by the hospital group and which fell within their domain was that of providing good medical and mental health care for victims. Before Center personnel arrived, guidelines for hospital staff had been drawn up by the group and were in the process of approval. They were based on the ACOG protocol and literature produced by other rape-related projects. Once they were implemented an enormous improvement in the quality of treatment was observed, largely because police and hospital staff knew exactly what to do and not to do.

Nevertheless, not being confident that the guidelines were as good as they could be or that they would be adhered to, the group planned a survey of victims who used the hospital services which would reveal the weaknesses of the system from the victim's point of view. They were concerned that they did not know what the real fears, needs and desires of rape victims were—nor did they know how they could be dealt with once they were identified.

3. *The Hospital Group*. The core of this group is six nurses and social workers and a psychiatrist who are on the staff of the hospital. They are all women—most are young and some are involved in the women's movement. Because

of their good standing with the hospital administration and the department of psychiatry, they gained the cooperation of the other medical professionals needed to bring about improvements at the hospital. A certain amount of their work has been done during the hours they were on duty, but much of it has been done on a volunteer basis.

Besides the medical guidelines and the survey described above, the group wanted to establish a counseling program and to publish a booklet for victims which would explain the medical examination and give names and numbers of organizations and agencies that could provide assistance and provide general information about the crime of rape to help women understand what had happened to them. At the time of the Center's first contact with them, the group had been meeting for nearly six months and was tired, although determined to persist with its plans.

The police legal advisor was also a part of this group, because of its hope that the police would cooperate in the hospital's effort to improve the treatment of sexually assaulted women. She had the confidence of the Police Chief and was meeting with the hospital contingent with his permission.

The Center became interested in the efforts of these Chapel Hill women because of their potential for demonstrating what can be done by highly motivated women whose positions and reputations within the relevant agencies might enable them to institute improvements and achieve coordination quickly.

During the first visit that Center consultants made to Chapel Hill, they rendered technical assistance to the hospital group in the writing of a funding proposal that was submitted in the LEAA Citizen's Initiative competition for cities and counties. Although the attempt to secure this funding was unsuccessful, it did provide the impulse to design a comprehensive program, to interest the Mayor of Chapel Hill and the County Board in the project, and to set up communications between the hospital and the law enforcement agencies.

The resignation of the Chapel Hill Police Chief and a prolonged period during which the office was not filled made it impossible for Center consultants to work directly with the department to improve its response to rape. However, at that time a training academy for officers from all over the state was planning a course related to the crime of rape and was able to benefit from the expertise of both a Center consultant and the hospital group.

The NOW chapter turned its attention to organizing a statewide coalition of rape crises centers and to lobbying for law change. It also operates under the name Chapel Hill-Carrboro Rape Crisis Center to do public speaking, provide information and referrals, and counsel victims who do not go to the hospital.

The hospital program, now run almost entirely by emergency room personnel and called the North Carolina Memorial Hospital Emergency Room Rape Crisis Center, has published its manual for rape victims. Funds for this were found in the hospital budget. It also provides counseling to rape victims who wish it. For several months after this capability was established, fewer than the usual number of victims appeared at the hospital. Perhaps because of a publicity campaign which was then staged, a larger number of victims have since availed themselves of the hospital's services.

The survey of victim responses to the crime, the criminal justice system, and the hospital treatment is also being carried out, although the sample is still too small to draw conclusions. It seems clear, nonetheless, that treatment of rape victims has improved in Orange County and that the changes which have been made have cost the community very little. They have developed, for the most, from the dedicated efforts of a small number of women who knew what was needed and were well placed professionally to obtain it.

E. Montgomery County, Maryland

Passage Crisis Center is a Montgomery County, Maryland agency which is part of the

Youth and Young Adult Services Program of the County Health Department. Montgomery County is adjacent to Washington, D.C. and has some of the most affluent suburbs in the United States. It still includes some rural areas, and parts of the county are beginning to encounter the problems of urban congestion and crime. Passage is designed to assist people in a variety of crisis and trauma situations. Its counselors can intervene in suicide attempts, family and school problems, runaway youth, drug and alcohol problems, as well as with rape victims. The agency has a paid staff of 14 people, a corps of approximately 40 volunteers who are trained in crisis intervention counseling; and 24-hour on-call psychiatric consultation. Counseling services are available 24 hours a day without charge.

The rape counseling program became operational in March 1975 after 7 months of planning designed to integrate this new service into the agency's program and into county law enforcement programs. A Sex Offenses Committee, comprised of county citizens and appointed by the County Council, had been investigating issues relating to the crime of rape and the problems of rape victims since 1973 and had initiated discussions in the summer of 1974 with Passage, a public agency dedicated to crisis intervention, regarding the development of a rape victim counseling component. It was appropriate for Passage to consider adding this new element to its program.

The Coordinator of Program Development at Passage was committed to the new service from the outset and undertook much of extensive liaison work with other county agencies. A member of the Center for Women Policy Studies project team served as a consultant to Passage. The consultant assisted in the development of training material for the staff, conducted two training sessions for full-time staff, and served as a resource in briefing county officials. The Center monitored the program from the initial contact with the Sex Offenses Committee through the first few weeks of program implementation, a period of 9 months.

The rape counseling component of the Passage Crisis Center was modeled on the institution's existing crisis intervention programs. It was intended that existing personnel—a combination of paid and volunteer staff—would conduct the counseling. Each program area of the crisis center (drugs, family counseling, etc.) has a coordinator. While any of the staff on duty might find it necessary to counsel a client in any of the crisis situations, the coordinator has administrative charge of the area and of all related program and evaluation data.

The Passage Crisis Center is part of a large county agency—the Health Department. However, the 24-hour work environment dealing with crisis intervention tends to engender a sense of autonomy among the staff. While it values and attempts to maintain this somewhat independent posture, it is still necessary to coordinate its activities with the overall goals of the agency. The new rape victim program requires further coordination of efforts with other relevant agencies, both public (such as police, mental health) and private (such as hospitals).

Developing effective working links has been particularly crucial in the establishment of the rape counseling program. This is so partly because client referrals often come from the agencies and partly because the victim often perceives that some of her problems are caused by her treatment within the same agencies. Sensitive to these considerations, Passage devoted much of the developmental period to briefing agencies on the proposed program, securing their approval, establishing linkages, and working out administrative barriers.

No extra staff was contemplated for the rape counseling program initially; the volume of clients for this program was expected to govern any requests for increased staff. Shortly after the program became operational, it became apparent that such counseling is an extremely labor-intensive effort. This is compounded by the necessity for dealing not only with the victim but also with the agencies with which she is involved.

A special publicity program to educate the community regarding the existence of rape victim counseling was carried out; it included posters, newspaper interviews, and public service spots in the media. Such publicity services are also part of general publicity efforts conducted twice a year by Passage.

The need for a victim counseling program in Montgomery County was established by the Sex Offenses Committee. Although the Committee's report and recommendations had not been issued, Committee members communicated with Passage staff and with the Center for Women Policy Studies requesting assistance. The Committee felt that Passage was the appropriate institution to handle such a program partly because it was in existence and was recognized. The Committee did feel that the program should not become operational until the task force final report and recommendations were issued. Because of delay in completing the work of the task force, the rape victim counseling program did begin before the report was issued.

An issue which was necessary to resolve at Passage was the question of whether to use male counselors. Whichever counselors are on duty at a given time, male or female, are responsible for responding to requests for help. Co-counseling with a full-time staff member and volunteer is the method used for walk-in clients. It is the policy of most rape crisis centers to provide only female counselors for rape victims, but the decision was made at Passage to continue its long-standing policy. Thus, male counselors or volunteers will eventually be called upon to assist rape victims. However, a female counselor will be available at all times to see a rape victim personally, so that a male does not co-counsel her with another male. During the early stages of the program's operation, all the staff was somewhat apprehensive about dealing with a victim and went to considerable lengths to refer rape victims immediately to the staff person with the greatest expertise with this client group.

Two training sessions were held for the staff utilizing materials developed and supplied by the Center for Women Policy Studies. These two, 5-hour sessions covered all aspects of counselor preparedness from how to deal with a call from the victim, to hospital and police procedures. Although these counselors were experienced in crisis intervention and had received specialized training, they expressed concern regarding their readiness to assist rape victims. This may reflect the counselors' realistic understanding of the scope of the victim's problems—ranging from fears for her physical safety because of threats by the rapist to acute disruption of her family and interpersonal relationships.

The volume of rape victim clients at Passage during the initial month of the program was small. This has been attributed to two factors. First, the availability of the Passage program is not well known despite efforts to publicize it. The availability of rape victim counseling is even less known. Second, the police do not regularly refer rape victims to Passage. However, an attractive booklet is distributed by the police department which informs rape victims about police, hospital and court procedures, and specifically mentions the counseling services provided by Passage. Thus, some victim initiative is necessary for her to seek out crisis counseling at Passage.

The experience at Passage has demonstrated several strengths which should be noted for other programs:

1) The program was developed and became operational in a relatively short time—about half a year with part-time input from staff. The program planning required 2-3 months with the rest of the period needed for briefings and negotiations with related agencies.

2) No additional funds were required to launch the service. While it was possible to implement the program at no cost, a high volume of clients could, of course, result in the need for additional staff.

3) The program made use of an existing public facility with capability for publicity, evaluation procedures, and other features which contribute to stabilizing a fledgling program.

The problem that is most immediately apparent on reviewing the Passage experience is the difficulty of inter-agency coordination. A great deal of the preparation period for Passage was devoted to either explaining the proposed program to their own or other county agencies or securing needed clearances to conduct the program. This step is necessary for a rape victim counseling program, because the service is so dependent on referrals by police and hospitals. At the close of the monitoring period, Passage had not yet secured the full cooperation of the police in the matter of victim referrals.

F. Pittsburgh, Pennsylvania

PAAR (Pittsburgh Action Against Rape) began as an offshoot of a NOW task force on rape. It was organized through the initiative of two Pittsburgh University women in cooperation with several rape victims. A core group of interested women formed, joined by the National Organization for Women and the Women's Political Caucus. A program evolved, patterned after other crisis hotline centers, and gradually the group expanded to include professional women, such as nurses, social workers, and lawyers.

In 1973, PAAR* testified before the Governor's Justice Commission regarding the need for services for rape victims. Then followed a lengthy period of proposal writing and gathering professional support and a staff. In August 1974 a contract of $53,200 was awarded by LEAA with $3,000 matching funds from the Women's Health Service and $3,000 from the state. The YWCA rents space to the group in McKeesport, Pennsylvania, a suburb of Pennsylvania. These funds made PAAR one of the most affluent rape crisis centers in a movement characterized by low budget, volunteer operations. The Center for Women Policy Studies undertook to monitor the Pittsburgh project for that reason.

PAAR (later Mon Yough-Allegheny County Rape Crisis Center)* is organized as a nonprofit corporation with an unpaid Board of Directors and a paid staff of three. An advisory board of legal/medical professionals in the community provides assistance with program development and outreach to agencies involved in treatment of rape victims. This structure apparently has contributed to PAAR's ability to gain community support for the program.

Direct victim services consist of a 24-hour hotline answered by the staff from 8 a.m. to 5 p.m. and an answering service and beeper system after 5 p.m. Community education has been a major thrust of the program with sessions held in schools, law enforcement agencies, civic groups, and with mental health agencies. A group of trained volunteers is used in victim counseling.

Because the organization has received considerable publicity in the local press and because of the cooperation of the police and hospitals in referrals, PAAR had what could be called a heavy volume of victim clients—100 or more during the first 6 months of operation. During the period in which PAAR was monitored by the Center for Women Policy Studies, the winter of 1975, the Pittsburgh rape crisis center appeared to be meeting the needs of victims and to have gained acceptance by a large number of law enforcement and social agencies as well as health and counseling professionals in the community.

Toward the end of the monitoring period, a conflict of major proportions surfaced between factions within PAAR. The Executive Director and the Chairperson of the Board of Directors differed strongly on program direction. The dispute was characterized by the Chairperson as being in part over whether PAAR in fact provided services with a feminist perspective. The conflict became increasingly intense, and ultimately the Executive Director of PAAR, along with a new Board of Directors, formed a new corporation and renegotiated the contract with the Governor's Justice Commission.

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*During the monitoring period, the name of the group being monitored changed from PAAR to Mon Yough-Allegheny County Rape Crisis Center.

The new organization was named the Mon Yough/Allegheny County Rape Crisis Center. Its geographic coverage was intended to be Allegheny County and it continued with the same staff and program as well as funds. PAAR continued to operate, under management of its remaining board members, but without funds its activities have relied on volunteer labor and have had to be curtailed. In a press release explaining its separation from the McKeesport center (Mon Yough-Allegheny), the Board of Directors of the PAAR announced that the center was "redirecting its goals for providing services to rape victims towards more supportive person-to-person aid. . . . This new program will focus on helping rape victims directly, rather than on building another unresponsive bureaucratic structure."

Some confusion undoubtedly occurred within the community as a result of the splintering of PAAR. Bitterness between the two factions did not dissolve with the separation into two institutions. There was, in addition, continuing press coverage of the controversy. The impact of this conflict on the effectiveness of both programs cannot be calculated as the split occurred near the end of the Center for Women Policy Studies monitoring period.

The Mon Yough-Allegheny County Rape Crisis Center (formerly PAAR) was and is among the most stable rape crisis centers in the country. During its initial 6 months it delivered supportive services to over 100 rape victims while setting up working links and conducting training programs for police and hospitals as well as carrying out a significant amount of community education. It has recently been instrumental in developing the Pennsylvania Coalition Against Rape, which includes a statewide network of rape crisis centers. Of course the budget provided through the LEAA contract made this stability and rapid expansion possible. But certain preconditions made it possible for the group to qualify for the criminal justice money in the first place. The Board members and committee heads included law enforcement, health, and mental health professionals who were well placed in their institutions to get the rape victim issues addressed. In addition, many had worked together over the years on other issues. But it is just this same heavy involvement with professionals that contributed to some of the conflict between the two factions and the charges of bureaucratic unresponsiveness and exclusion of feminists from decision-making positions.

*U.S. GOVERNMENT PRINTING OFFICE:1976 211-063/540 1-3

PRESCRIPTIVE PACKAGE: "RAPE AND ITS VICTIMS: A REPORT FOR CITIZENS, HEALTH FACILITIES, AND CRIMINAL JUSTICE AGENCIES"

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☐ Modifying existing projects
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